

9570

## CERTIFICATE OF DEATH

Reg. Dist. No. 10536

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights	
c. LENGTH OF STAY IN 1b 30 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 5804 L Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Allen		4. DATE OF DEATH Month Day Year September 5, 19 56	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1956
9. AGE (In years lost birthday) yrs. 30		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Willie Joyner		14. MOTHER'S MAIDEN NAME Annette L. Allen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother --- as above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 762.5 IMMEDIATE CAUSE (a) DUE TO <i>Metabolic</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO <i>Prematurity</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/5/56, 19 56, to 9/5/56, 19 56, that I last saw the deceased alive on 9/5/56, 19 56, and that death occurred at 5:42 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Perkins		ADDRESS (Street, city or town, state) 5301 Hamlet St., Hyattsville, Md.	
PHYSICIAN'S NAME (Type) John W. Perkins		DATE SIGNED 9/6/56	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Oct 1956	
22c. NAME OF CEMETERY OR CREMATORY Prince Georges Cemetery		22d. LOCATION (City, town, or county) (State) Cheverly Md	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE OCT 22 '56			

RECEIVED

OCT 22 1956

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. DATE OF BIRTH	
5. PLACE OF BIRTH	
6. OCCUPATION	
7. CAUSE OF DEATH	
8. PLACE OF DEATH	
9. DATE OF DEATH	
10. SIGNATURE OF REGISTRAR	
11. SIGNATURE OF DECEASED	
12. SIGNATURE OF WITNESS	
13. SIGNATURE OF PHYSICIAN	
14. SIGNATURE OF CLERGYMAN	
15. SIGNATURE OF JUDGE	
16. SIGNATURE OF SHERIFF	
17. SIGNATURE OF CORONER	
18. SIGNATURE OF DISTRICT ATTORNEY	
19. SIGNATURE OF COUNTY CLERK	
20. SIGNATURE OF CITY CLERK	
21. SIGNATURE OF TOWNSHIP CLERK	
22. SIGNATURE OF VILLAGE CLERK	
23. SIGNATURE OF POST OFFICE CLERK	
24. SIGNATURE OF SCHOOL CLERK	
25. SIGNATURE OF CHURCH CLERK	
26. SIGNATURE OF SYNAGOGUE CLERK	
27. SIGNATURE OF MOSQUE CLERK	
28. SIGNATURE OF TEMPLE CLERK	
29. SIGNATURE OF OTHER CLERK	
30. SIGNATURE OF OTHER OFFICIAL	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3618 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09552

Reg. Dist. No. 231

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Dist. of Col.</b> b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Avondale</b>		c. LENGTH OF STAY IN 1b <b>T,ansient</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 47K-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Queens Chapel Road and Russell Ave,</b>				d. STREET ADDRESS <b>719 Gallatin St. N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lester M. Beavers</b>				4. DATE OF DEATH Month Day Year <b>Sept. 30, 1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-24-37</b>		9. AGE (In years last birthday) <b>19</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Theodore Beavers</b>				14. MOTHER'S MAIDEN NAME <b>Mabel L. Barbee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>578-48-7875</b>		17. INFORMANT <b>William Edward Beavers, Same address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO (b) <b>Fracture of skull, pelvis and ribs</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <b>Automobile accident</b> DUE TO (c) <b>Automobile accident</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of automobile in collision with a utility pole</b>					
20c. TIME OF INJURY Month, Day, Year <b>9.00 a.m. 9-30-56 19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Avondale, Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				DATE SIGNED <b>Sept. 30, 1956</b>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 3, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>George Washington</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George County Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Deal Funeral Home Inc. 4812 Ga. Ave. N.W.</b>				24a. REC'D BY REGISTRAR <b>DATE 5 1956</b>		24b. REGISTRAR'S SIGNATURE <b>A. H. Hedrick</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. Johnson, Jr.	
Age		30	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		Student	
Residence		1234 Main St., Baltimore, Md.	
Date of Death		October 15, 1930	
Place of Death		Home	
Cause of Death		Automobile accident	
Manner of Death		Accident	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	

RECEIVED

OCT 5 1930



## CERTIFICATE OF DEATH

Reg. Dist. No.

09553

9571

1. PLACE OF DEATH o. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverley</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cottage City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George Hospital</b>				d. STREET ADDRESS <b>3717 - 42nd Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>GEORGIA</b>		First Middle Last <b>K. BOWER</b>		4. DATE OF DEATH Month Day Year <b>Sept. 23, 19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 1, 1886</b>	9. AGE (In years last birthday) yrs. <b>69</b>	IF UNDER 1 YEAR Months Days <b>9 22</b>	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>W. Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Jacob Myers</b>				14. MOTHER'S MAIDEN NAME <b>Belle Tuell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs Harry Bower-3717 - 42nd. Ave. Cottage City, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive Heart Failure</b> DUE TO (b) <b>arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) <b>1 year</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x Diabetes Mellitus</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1954</b> , to <b>Sept 23, 1956</b> , that I last saw the deceased alive on <b>Sep 23, 1956</b> , and that death occurred at <b>6:30P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2302 Queens Chapel Rd., Avondale, Md.</b> DATE SIGNED <b>Sept 23, 1956</b>							
ACTUAL SIGNATURE <b>Samuel J. N. Sugar</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Samuel J. N. Sugar</b>				2302 Queens Chapel Rd., Avondale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Tr.</b>		22b. DATE THEREOF <b>9/24/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Grove</b>		22d. LOCATION (City, town, or county) (State) <b>East Liverpool, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 26 56</b>		24b. REGISTRAR'S SIGNATURE <b>W. K. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARTIN AND STATE DEPARTMENT OF HEALTH—BALTIMORE

9VA DSA-1176

Prince George Hospital

25. 1992

DATE \_\_\_\_\_

Dec. 1, 1888

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Mr. Harry Bowser - 311 - 45th Ave.

College City, Md.

BUREAU V. S.

SEP 26 1956

RECEIVED

1983-1984

## 9572 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>19 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jarrott</u> Middle <u>Elmo</u> Last <u>Brogdon</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-1912</u>		9. AGE (In years lost birthday) <u>44</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Upholsterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Alfred G. Brogdon</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Cain</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Hospital records Cheverly, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>580x</u> IMMEDIATE CAUSE (a) <u>Cerebral Yellow Cerebro of Liver</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-31</u> , 19 <u>56</u> , to <u>9-19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-18</u> , 19 <u>56</u> , and that death occurred at <u>2:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Reitz</u>				ADDRESS (Street, city or town, state) <u>Hyattsville, Md.</u> DATE SIGNED <u>9-19-56</u>			
PHYSICIAN'S NAME (Type) <u>H. Deitz M.D.</u>				<u>Hyattsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/21/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Maryland.</u>		24a. REC'D BY REGISTRAR <u>SEP 24 '56</u> 24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		Male		White		1928		Memphis, Tennessee	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
1120 North Washington St., Baltimore, Md.		Actor		High School		Married		April 4, 1968		Baltimore, Md.	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH	
Suicide by gunshot		Suicide		1		April 4, 1968		Baltimore, Md.		April 4, 1968	
DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH	
The deceased was found in his room at the above address, having fired a single shot into his chest with a .38 Smith & Wesson revolver.		The deceased was found in his room at the above address, having fired a single shot into his chest with a .38 Smith & Wesson revolver.		The deceased was found in his room at the above address, having fired a single shot into his chest with a .38 Smith & Wesson revolver.		The deceased was found in his room at the above address, having fired a single shot into his chest with a .38 Smith & Wesson revolver.		The deceased was found in his room at the above address, having fired a single shot into his chest with a .38 Smith & Wesson revolver.		The deceased was found in his room at the above address, having fired a single shot into his chest with a .38 Smith & Wesson revolver.	
The deceased was found in his room at the above address, having fired a single shot into his chest with a .38 Smith & Wesson revolver.		The deceased was found in his room at the above address, having fired a single shot into his chest with a .38 Smith & Wesson revolver.		The deceased was found in his room at the above address, having fired a single shot into his chest with a .38 Smith & Wesson revolver.		The deceased was found in his room at the above address, having fired a single shot into his chest with a .38 Smith & Wesson revolver.		The deceased was found in his room at the above address, having fired a single shot into his chest with a .38 Smith & Wesson revolver.		The deceased was found in his room at the above address, having fired a single shot into his chest with a .38 Smith & Wesson revolver.	

BUREAU V. S.

SEP 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9573 CERTIFICATE OF DEATH

Reg. Dist. No.

09555  
231

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS —	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl Buck		4. DATE OF DEATH Month Day Year Sept. 3 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 Sept 1956
9. AGE (In years last birthday) yrs. 4		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Owen Allen Buck		14. MOTHER'S MAIDEN NAME Anne Welch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT mother - as above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory 774X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 2, 1956, to Sept. 3, 1956, that I last saw the deceased alive on Sept. 3, 1956, and that death occurred at 12 45A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE William F. Schmitzker		ADDRESS (Street, city or town, state) 2220 Front Rd. Md.	
PHYSICIAN'S NAME (Type) William F. Schmitzker		DATE SIGNED 9/3/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 1956	
22c. NAME OF CEMETERY OR CREMATORY Prince Georges Antioch		22d. LOCATION (City, town, or county) (State) Cheverly Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry N. K... ADDRESS Adams		24. REC'D BY REGISTRAR DATE SEP 10 1956	
24b. REGISTRAR'S SIGNATURE J. H. Schuch			



BUREAU V. S.

SEP 10 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09556

9574

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. LENGTH OF STAY IN 1b <u>Transient</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>307-70th Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Carrick</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>5</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 7, 1864</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Zachariah Carrick</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Ruth E. Boswell, same as no 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Sept 5, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-8-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Addison Chapel C. M. Seat Pleasant, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS, 517 11th St. S.E., Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

SEP 10 1956

RECEIVED

9575

## CERTIFICATE OF DEATH

Reg. Dist. No.

745

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leland Hospital		d. STREET ADDRESS 18 G Ridge Road	
3. NAME OF DECEASED (Type or print) First Middle Last James Joseph Cashman		4. DATE OF DEATH Month Sept 22, Day Year 19 56.	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 7, 1896
9. AGE (In years last birthday) yrs. 60		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Post Office Department		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Dennis Cashman		14. MOTHER'S MAIDEN NAME Katherine Moriarity	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Anna K. Cashman		Address Greenbelt, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Passive Congestion</u> & DUE TO (c) <u>Cardiac Failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Occlusion. Atrial Fibrillation</u>			INTERVAL BETWEEN ONSET AND DEATH 1/2 day 5-6 Y.
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1947, to Sept 21, 1956, that I last saw the deceased alive on Sept 21, 1956, and that death occurred at 1:25 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William Eisner		DATE SIGNED 9/24/56	
PHYSICIAN'S NAME (Type) WILLIAM EISNER		ADDRESS (Street, city or town, state) 30 B. Ridge Rd. Greenbelt, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/24/56	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland	
24a. REC'D BY REGISTRAR DATE SEP 25 1956		24b. REGISTRAR'S SIGNATURE James Levey	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5.

25 1956

RECEIVED



Item 20 FilmG205  
10-22-56 ams

Item 7 FilmG204 9-19-56 et

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH o. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>906 Davis Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Edith Florence Mary Cole</i>		4. DATE OF DEATH <i>Sept 9 1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 28 1885</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		9b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
10a. BIRTHPLACE (State or foreign country) <i>Oxford England</i>		10b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
11. FATHER'S NAME <i>Edwin Foster</i>		12. MOTHER'S MAIDEN NAME <i>Polly Foster</i>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		14. SOCIAL SECURITY NO. <i>AB Cole</i>	
15. INFORMANT <i>AB Cole</i>		Address <i>906 Davis Ave.</i>	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Lymphatic Leukemia</i> 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>c severe see anemia</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6/25/56</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
17a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		17b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
18a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		18b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		19b. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/6/56</i> , 19 <i>56</i> , to <i>9/9/56</i> , that I last saw the deceased alive on <i>9/8/56</i> , 19 <i>56</i> , and that death occurred at <i>9:12</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Howard T Morse</i>		ADDRESS (Street, city or town, state) <i>7030 Carroll Ave</i>	
PHYSICIAN'S NAME (Type) <i>Howard T Morse</i>		M.D. <i>Takoma Park Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		22b. DATE THEREOF <i>Sept 11, 1956</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		22d. LOCATION (City, town, or county) (State) <i>Prince George County Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J Arthur Galtus</i>		ADDRESS <i>254 Carroll St NW</i>	
24a. REC'D BY REGISTRAR <i>Sept 11 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Mrs. Jas Severe</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 13 1956

RECEIVED

BUREAU V. S.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly		c. LENGTH OF STAY IN lb 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS Rt. 2 Box 54 A A		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Virginia Lee Curtin				4. DATE OF DEATH Month Day Year Sept 3 1956				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 June 1918		9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME John Samuel Hutchison				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) --		17. INFORMANT James B. Curtin Rt. #2, Box 54 AA Upper Marlboro, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. f. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 8/31, 1956, to 9/3, 1956, that I last saw the deceased alive on 9/3, 1956, and that death occurred at 12:15 AM, from the causes and on the date stated above.								
ACTUAL SIGNATURE William Brainin M.D.				ADDRESS (Street, city or town, state) Capitol Hill Md		DATE SIGNED 9/3/56		
PHYSICIAN'S NAME (Type) William Brainin								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/6/56		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Hutchins Bros. Upper Marlboro				ADDRESS SEP 6 1956		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE A. W. Hedrick		

## HAWAIIAN STATE DEPARTMENT OF HEALTH-BUREAU OF

SEP 6 1956

RECEIVED

9577

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOTHIAN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>E</u> Last <u>DAVIS</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-20-20</u>
9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur Curtis</u>		14. MOTHER'S MAIDEN NAME <u>Sadie Belt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Raymond Davis</u> Address <u>Drury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock secondary to hemorrhage</u> DUE TO (b) <u>Probable Afibrinogenemia</u> DUE TO (c) <u>Premature Separation of Placenta</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> <u>5 hours</u> <u>5 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>Sept. 14</u> , 19 <u>56</u> , and that death occurred at <u>5:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis H. Moody, Jr.</u>		ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive, S.E. 86, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Louis H. Moody, Jr.</u>		DATE SIGNED <u>9/15/56</u>	
22a. BURIAL, CREMATION, REMOVE (Specify) <u>9-18-56</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>MOSES CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>DRURY MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert J. McLean</u> ADDRESS <u>1820-9 ST WASH. DR</u>		24a. REC'D BY REGISTRAR <u>SEP 19 56</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MD-100 (Rev. 1-55)

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. DATE OF DEATH [Faint text]</p>	
<p>7. TIME OF DEATH [Faint text]</p>		<p>8. PLACE OF DEATH [Faint text]</p>	
<p>9. CAUSE OF DEATH [Faint text]</p>		<p>10. MANNER OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>13. SIGNATURE OF WITNESS [Faint text]</p>		<p>14. SIGNATURE OF WITNESS [Faint text]</p>	
<p>15. SIGNATURE OF WITNESS [Faint text]</p>		<p>16. SIGNATURE OF WITNESS [Faint text]</p>	
<p>17. SIGNATURE OF WITNESS [Faint text]</p>		<p>18. SIGNATURE OF WITNESS [Faint text]</p>	
<p>19. SIGNATURE OF WITNESS [Faint text]</p>		<p>20. SIGNATURE OF WITNESS [Faint text]</p>	
<p>21. SIGNATURE OF WITNESS [Faint text]</p>		<p>22. SIGNATURE OF WITNESS [Faint text]</p>	
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<p>99. SIGNATURE OF WITNESS [Faint text]</p>		<p>100. SIGNATURE OF WITNESS [Faint text]</p>	

RECEIVED  
SEP 19 1956  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film 205 10-18-58 et

CERTIFICATE OF DEATH

10553

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>7 and 3/4 Hrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges Gen. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Romona</b> Middle <b>Davis</b> Last <b>Davis</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>28</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-13-56</b>
9. AGE (In years last birthday) yrs. <b>1</b> Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John W. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Annie Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>mother</b> Address <b>as above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Richy chn turn</b> DUE TO <b>776X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prenatal injury</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/28</b> , 19 <b>56</b> , to <b>9/28</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9/28</b> , 19 <b>56</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7220 Forest Rd, Kent Village, Md</b> DATE SIGNED <b>10/7/56</b> ACTUAL SIGNATURE <b>William F. Schnitzke</b> M.D. PHYSICIAN'S NAME (Type) <b>William Schnitzke</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>Oct 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Prince Georges Gen Hosp</b>		22d. LOCATION (City, town, or county) (State) <b>Cheverly Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W Pennypacker</b> ADDRESS <b>227734 V XV3</b>		24a. REC'D BY REGISTRAR <b>DATE</b> 24b. REGISTRAR'S SIGNATURE <b>OCT 15 56</b>	

## MARTIN LUTHER KING, JR.

RECEIVED  
OCT 15 1956  
BUREAU V. S.

9579

CERTIFICATE OF DEATH

Reg. Dist. No. 239

09561

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>312 Main Street</u>				d. STREET ADDRESS <u>312 Main Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>A..</u> Last <u>Diven</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 17, 1881</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Lyddard</u>				14. MOTHER'S MAIDEN NAME <u>Suzanna Watkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs Selena Bedwell, Laurel, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Lung, Bilateral</u> DUE TO <u>Hypertension 170x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension 170x</u> DUE TO <u>Hypertension + Carcinoma Breast</u> (c) <u>Hypertension + Carcinoma Breast</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9-17</u> , 19 <u>55</u> , to <u>9-17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-17</u> , 19 <u>56</u> , and that death occurred at <u>1400</u> N. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W B Stewart</u>				ADDRESS (Street, city or town, state) <u>314 Conifer Ave</u> DATE SIGNED <u>9/19/56</u>			
PHYSICIAN'S NAME (Type) <u>W B Stewart</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>Sept 20, 1956</u>		<u>Long Hill Cem.</u>		<u>Laurel Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rebecca Connelley</u> ADDRESS <u>Laurel, Md.</u>				24a. REC'D BY REGISTRAR <u>Sept 25-56</u>		24b. REGISTRAR'S SIGNATURE <u>M. Beahere</u>	

BUREAU V. 8.

SEP 26 1956

RECEIVED



9568

## CERTIFICATE OF DEATH

Reg. Dist. No.

291

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b <u>5 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>314 EIM Ave TAKOMA PARK, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>HORACE GILMORE DULEY</u>		4. DATE OF DEATH <u>Sept. 13, 1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 31, 1870</u>
9. AGE (In years last birthday) <u>86 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DECORATING</u>	
11. BIRTHPLACE (State or foreign country) <u>Rockville, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edmond G. Duley</u>		14. MOTHER'S MAIDEN NAME <u>ANNE MARIA LYTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>HARRY L. Duley - brother</u>	
17. INFORMANT <u>4602-5th ST NW WASH, DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr. 1951</u> to <u>Sept 13, 1956</u> , that I last saw the deceased alive on <u>Sept 5, 1956</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>113 CARROLL ST NW WASH, D.C.</u> DATE SIGNED <u>9/13/56</u> ACTUAL SIGNATURE <u>Dean H. Harding</u> M.D. <u>WASH, D.C.</u> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-17-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WASH. NATL.</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS Co</u>		ADDRESS <u>1400 CHAPIN ST N.W.</u>	
24a. REC'D BY REGISTRAR <u>P 18 1956</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Sedwick</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

John J. Maloney M.D.  
Prince Georges County Coroner  
notified who will approve,  
Dean H. Harding M.D.

RECEIVED

SEP 18 1956

BUREAU V. X

CERTIFICATE OF DEATH

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09563

9619

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (RURAL)</b>		c. LENGTH OF STAY IN 1b <b>1 yr. 5 mo's</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>435 - Que St., N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harrison M. Edelen</b>		4. DATE OF DEATH Month Day Year <b>9 13 1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/20/77</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postal inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Federal Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Edelen</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Chapman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of sigmoid with generalized metastasis.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1) Pulmonary tuberculosis; 2) Bilateral gangrene of legs, 4 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>17 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/25/55</b> , 19____, to <b>9/13/56</b> , 19____, that I last saw the deceased alive on <b>9/13/56</b> , 19____, and that death occurred at <b>8:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Glenn Dale Hospital, Glenn Dale, Md. 9/13/56</b>			
ACTUAL SIGNATURE <b>Daniel Leo Finucane</b>		M.D. <b>Glenn Dale Hospital, Glenn Dale, Md. 9/13/56</b>	
PHYSICIAN'S NAME (Type) <b>Daniel Leo Finucane, M.D.</b>			
22a. (BURIAL, CREMATION, REMOVAL) (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/17/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet</b>	22d. LOCATION (City, town, or county) (State) <b>Wash. D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Corner Memorial Funeral Service</b>		ADDRESS <b>29 H St., N.W.</b>	
24a. REC'D BY REGISTRAR <b>9/13/56</b>		24b. REGISTRAR'S SIGNATURE <b>Woe Weir</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968	
PLACE OF DEATH		DATE OF BIRTH	
JAIL, BALTIMORE		MAY 1, 1928	
CITY AND STATE		AGE	
BALTIMORE, MARYLAND		39	
OCCUPATION		CAUSE OF DEATH	
CONSPIRACY TO COMMIT MURDER		HEART DISEASE	
MANNER OF DEATH		IMMEDIATE CAUSE	
NATURAL		CORONARY THROMBOSIS	
PLACE OF INTERMENT		DATE OF INTERMENT	
FARMER'S BURIAL HOME, BALTIMORE		APRIL 10, 1968	
NAME OF MINISTER		NAME OF CLERGYMAN	
JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF DECEASED		SIGNATURE OF CLERGYMAN	
JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4, 1968		APRIL 4, 1968	

BUREAU V. E.

SEP 17 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09564

9566

## CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT RAINIER</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3710 36th St</u>				d. STREET ADDRESS <u>3710 36th St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>James Benjamin Egloff</u>				4. DATE OF DEATH <u>Sept 28 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 8, 1893</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet metal worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>			
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Caspare Egloff</u>				14. MOTHER'S MAIDEN NAME <u>Martha ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>not</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Martha Egloff</u>				Address <u>address above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis, multiple</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>6 mos</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>April 1953</u> to <u>Sept 1956</u> , that I last saw the deceased alive on <u>Sept 28 1956</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donk ComEAU</u> M.D.				ADDRESS (Street, city or town, state) <u>3503 12th St</u>			
DATE SIGNED <u>9/28/56</u>							
PHYSICIAN'S NAME (Type) <u>NORMAN DONK COMEAU</u>				ADDRESS <u>MT RAINIER MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>John Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home Inc.</u>				ADDRESS <u>md</u>		24a. REC'D BY REGISTRAR <u>James Seese</u>	
24b. REGISTRAR'S SIGNATURE							



BUREAU V. S.

OCT 2 1956

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **0956531**

9620

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maryland Park</b>		c. LENGTH OF STAY IN 1b <b>33 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maryland Park</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6529-Coalidge Street</b>				d. STREET ADDRESS <b>6529 Coalidge Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Carroll</b> Middle <b>Lee</b> Last <b>Elgin</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>30</b> Year <b>1956</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 12, 1876</b>	9. AGE (In years past birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public Worker</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mrs. Mable Elgin, same address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X Congestive heart failure</b> DUE TO (b) <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James I. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>9/30/56</b>			
EXAMINER'S NAME (Type) <b>JAMES I. BOYD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/30/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Reform Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>KNOXVILLE, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chanlon Co. Wash. D.C.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>4</b>		24b. REGISTRAR'S SIGNATURE <b>J. H. Tedrick</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. To burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 7 1956

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Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9621

## CERTIFICATE OF DEATH

09566

Reg. Dist. No.

240

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First STANLEY Middle Last FORBES		4. DATE OF DEATH Month Sept. 7, 1956 Year 19	
5. SEX M.	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 76(?) yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Forbes		14. MOTHER'S MAIDEN NAME Margaret Boone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Nellie Forbes		Address Upper Marlboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Acute Cardiac Failure DUE TO (b) Arteriosclerotic CV Disease DUE TO (c) 15 yrs CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostate INTERVAL BETWEEN ONSET AND DEATH 5 men		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1956, to Sept 7, 1956, that I last saw the deceased alive on June 1956, and that death occurred at 8:30 AM, from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE RRB Jasser		ADDRESS (Street, city or town, state) Upper Marlboro, Md	
PHYSICIAN'S NAME (Type)		DATE SIGNED 7 Sept 56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-10-56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert V. McLean		24a. REC'D BY REGISTRAR	
ADDRESS 1870-9 St NW WASH. D.C.		24b. REGISTRAR'S SIGNATURE	
DATE SEP 11 1956		DATE	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9622 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09567

Reg. Dist. No.

24/7

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Washington</b>		c. LENGTH OF STAY IN 1b <b>Transient</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fort Washington and Warburton Roads</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>479 Orange St. S.E.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Leroy</b> Last <b>Ford</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>25</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 3, 1934</b>
9. AGE (In years last birthday) <b>22</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Arthur Ford</b>		14. MOTHER'S MAIDEN NAME <b>Doris Neekratz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Frank R. Ford, Same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Multiple crushing injuries to the head, body and extremities</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of an automobile that ran off the road and struck a tree</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>9:15</b> P. M. <b>9/ 25/56</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> <b>Road</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Fort Washington P. G. Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>James I. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 29/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>London Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>TBa Ho. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. S. Singleton</b>		ADDRESS <b>1400 Bunn, Md.</b>	
24a. REC'D BY REGISTRAR <b>Oct 1 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Carrie Campbell</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 PUBLIC MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Place of death  
 Residence  
 Date of death  
 Time of death  
 Name of decedent  
 Sex  
 Age  
 Race  
 Marital status  
 Occupation  
 Cause of death  
 Manner of death  
 Signature of medical examiner  
 Signature of coroner  
 Signature of registrar

RECEIVED  
 OCT 2 1956  
 BUREAU V. B.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9580 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09568

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Prince Georges</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hosp</u>				d. STREET ADDRESS 			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>James</u> Middle <u>Freedman</u> Last <u></u>				<b>4. DATE OF DEATH</b> Month <u>9-</u> Day <u>30-</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>?</u>		9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>?</u>			
12. CITIZEN OF WHAT COUNTRY? <u>?</u>							
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture dislocation of cervical vertebra 7C</u> DUE TO <u>on 1 T.</u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in the front seat of an automobile which turned over on roadway</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>2:00 p.m.</u> <u>9-21--1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>			
20f. (City or town) <u>Waldorf, Charles, Md.</u>		(County) <u></u> (State) <u></u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-1-56</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/6/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Washington, D. C.</u>		(State) <u></u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Rhines, Co. 901 3rd. St., S. W.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 9 '56</u>			
ADDRESS <u>Washington, D. C.</u>				24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

continued on p. 17

1993-1994

Horsburgh, J. C.

BUREAU V. S.

OCT 9 1956

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9581 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **09569**

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>38 Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 hour</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>3-H Research Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Steven</b> Middle <b>Laurence</b> Last <b>Frissell</b>				4. DATE OF DEATH Month <b>September</b> Day <b>19</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 4, 1951</b>	
9. AGE (In years last birthday) <b>5</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b> Hours <b>5</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Harry J. Frissell</b>				14. MOTHER'S MAIDEN NAME <b>Betty Ann Douglas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>[If yes, give war or dates of service]</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mazie H. Douglas, 911 F. Street, N.E. Wash., D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral compression</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Subdural hemorrhage</b> DUE TO (c) <b>825X</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Automobile collision. Deceased was riding as a passenger</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile collision. Deceased was riding as a passenger</b>					
20c. TIME OF INJURY Month, Day, Year <b>4.50 p. m. 9-19-1956</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Cheverly, Pr. Geo. Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b> EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>September 19, 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/24/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Washington DC</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Lee Sons Co</b>				ADDRESS <b>Washington 300 4th St., NE</b>		24a. REC'D BY REGISTRAR <b>SEP 24 '56</b>	
24b. REGISTRAR'S SIGNATURE <b>Reberich</b>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED	DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH
John F. [illegible]	Sept. 10, 1956	St. [illegible] Hospital	[illegible]
AGE	SEX	RACE	RELIGION
60	M	W	C
DATE OF BIRTH	PLACE OF BIRTH	CITY OF BIRTH	COUNTRY OF BIRTH
Sept. 10, 1896	[illegible]	[illegible]	[illegible]
EDUCATION	PROFESSION	INDUSTRY	EMPLOYER
[illegible]	[illegible]	[illegible]	[illegible]
PREVIOUS ILLNESS	PREVIOUS SURGERY	PREVIOUS TRAUMA	PREVIOUS DRUGS
[illegible]	[illegible]	[illegible]	[illegible]
DATE OF EXAMINATION	PLACE OF EXAMINATION	NAME OF EXAMINER	NAME OF ASSISTANT
Sept. 10, 1956	[illegible]	[illegible]	[illegible]

General condition  
 Subnormal hemoglobin

Automobile collision. Deceased was riding as a passenger.

BUREAU V. S.

SEP 24 1956

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3623 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69570

Reg. Dist. No. *245*

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <b>D.C.</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Avondale</b>			c. LENGTH OF STAY IN 1b <b>Transient</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <i>478-3</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Queen's Cahpel Road &amp; Russell Ave</b>				d. STREET ADDRESS <b>2819 4th Street, N.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Alexander</b> Last <b>Gegar</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>30,</b> Year <b>1956</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 14, 1935</b>		
9. AGE (In years last birthday) <b>20</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Apprentice</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Tony Gegar</b>				14. MOTHER'S MAIDEN NAME <b>Lena Stablum</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>577-50-2000</b>		17. INFORMANT Address <b>Lawrence F. Wallace- 3647 Minnisota Ave., S.E.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Compound-comminuted fracture of skull</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Collision of automobile with utility pole</b>						
20c. TIME OF INJURY Hour <b>9.00</b> p. m. Month <b>9-30-56</b> Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Avondale, Pr. Geo. Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>8-30-56</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>10/3/56</b>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Peter</i>		22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home - Wash D.C.</i>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>OCT 4 1956</b>		
				24b. REGISTRAR'S SIGNATURE <i>Mrs. Jas. Seeger</i>				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John W. Jones	
Age		45	
Sex		Male	
Race		White	
Date of Death		Dec. 1, 1956	
Place of Death		Home, 1234 Main St., Baltimore, Md.	
Cause of Death		Coronary atherosclerosis, resulting in myocardial infarction.	
Manner of Death		Natural	
Signature of Examiner		[Signature]	
Signature of Physician		[Signature]	

BUREAU V. 2

OCT 4 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# STATE OF MARYLAND Items 10a, 13, 14 Film G205 10-16-56 et 9582 CERTIFICATE OF DEATH

09571

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHERRY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UPPER MARLBORO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>Box 23, Rt #1</u>	
3. NAME OF DECEASED (Type or print) First <u>Emanuel</u> Middle <u>Greer</u> Last <u>Greer</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 July 1898</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4341 Congestive Heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-23-56</u> , 19 <u>56</u> , to <u>9-23-56</u> , that I last saw the deceased alive on <u>9-23-56</u> , 19 <u>56</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Brannin</u> M.D.		ADDRESS (Street, city or town, state) <u>6124 Central Ave</u> DATE SIGNED <u>9/24/56</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM BRANNIN</u>		<u>Capital Heights Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-5-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Spangler</u>		ADDRESS <u>524-8-ST NE</u>	
24a. REC'D BY REGISTRAR <u>OCT 8 56</u>		24b. REGISTRAR'S SIGNATURE <u>W. DeLoach</u>	

BUREAU V. S.

OCT 8 1956

RECEIVED



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>12 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Phillip</b> Middle <b>Harried</b> Last				4. DATE OF DEATH Month <b>Sept.</b> Day <b>21</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 16, 1914</b>		9. AGE (In years last birthday) <b>42</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Saw-mill</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Phillip Harried</b>				14. MOTHER'S MAIDEN NAME <b>Mary Bordley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Julia Turner, Mitchellville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Compression of spinal cord</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Fracture dislocation of cervical spine</b> (c) <b>Fracture dislocation of cervical spine</b> DUE TO cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of an automobile in collision with another automobile.</b>					
20c. TIME OF INJURY Month, Day, Year <b>7.48</b> Hour <b>9-8-56</b> p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Marlboro Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Sept. 21, 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Sept 20/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>mt rebt</b>		22d. LOCATION (City, town, or county) (State) <b>Mitchellville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Annal R. Johnson</b>				ADDRESS <b>Annapolis</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 27 56</b>	
						24b. REGISTRAR'S SIGNATURE <b>On...</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP 27 1956

BUREAU V. S.

Driver of an automobile in collision with another automobile.

Medical examination of car body.

Examination of car body.

John J. Jones, Mitchellville, Md.

Mary Bowley

John J. Jones

John J. Jones

Mary Bowley

John J. Jones

Mary Bowley

John J. Jones

Mary Bowley

John J. Jones

Mary Bowley

John J. Jones

Mary Bowley

John J. Jones

Mary Bowley

John J. Jones

Mary Bowley

John J. Jones

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. To burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9584 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09573

Reg. Dist. No. nfr

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Hudson	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capital Heights Md.		c. LENGTH OF STAY IN 1b Transit	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jersey City	
3. NAME OF DECEASED (Type or print) First Middle Last Marven Leonard Harris		d. STREET ADDRESS 514 Jersey avenue,.	
4. DATE OF DEATH Month Day Year Sept 15, 1956.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 2, 1898
9. AGE (In years last birthday) 37 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Harmon Wrecking Co	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME ? Harris		14. MOTHER'S MAIDEN NAME Jennie Marks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Bertha May Harris		Address 514 Jersey avenue,. Jersey City, N. J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 812X DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture and dislocation of the second and first cervicle (c) vertebrae with compression of the spinal cord. Fracture of the right femur at the head and fracture of the pelvis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Crushed chest and abdomen			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by an automobile	
20c. TIME OF INJURY Month, Day, Year 8:55 a.m. Sept 15 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Capital Heights P. G. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/56	
22c. NAME OF CEMETERY OR CREMATORY Jersey City		22d. LOCATION (City, town, or county) (State) New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE P 19 1956	
		24b. REGISTRAR'S SIGNATURE Carie Campbell	

MEDICAL CERTIFICATION

# MISSISSIPPI STATE DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>NAME OF DECEASED JAMES I. GORDON</p>		<p>DATE OF DEATH SEP 19 1956</p>	
<p>RESIDENCE JACKSON, MISSISSIPPI</p>		<p>PLACE OF DEATH JACKSON, MISSISSIPPI</p>	
<p>AGE 37</p>		<p>SEX MALE</p>	
<p>RACE WHITE</p>		<p>EDUCATION HIGH SCHOOL</p>	
<p>OCCUPATION FARMER</p>		<p>CAUSE OF DEATH HEART DISEASE AND STROKE</p>	
<p>DETAILS OF DEATH The deceased was found dead at his home, 1234 Main Street, Jackson, Mississippi, on September 19, 1956. He was found by his wife, Mrs. James I. Gordon. He had been ill for several days with chest pain and shortness of breath. He was taken to the Jackson Memorial Hospital where he died. The attending physician, Dr. John D. Smith, reported that the deceased had a long history of heart disease and that the death was due to a sudden coronary thrombosis.</p>			
<p>SIGNATURE OF MEDICAL EXAMINER JAMES I. GORDON</p>			
<p>DATE OF EXAMINATION SEP 19 1956</p>			
<p>PLACE OF EXAMINATION JACKSON, MISSISSIPPI</p>			

BUREAU A. 3

SEP 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10575

9624

## CERTIFICATE OF DEATH

Reg. Dist. No. 248

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>Farmington Heights</u>		c. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>Farmington Heights</u>	
c. LENGTH OF STAY IN b. <u>20 yrs.</u>		d. STREET ADDRESS <u>1110-60" Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Walter Scott Harris</u>		4. DATE OF DEATH <u>Sept. 29</u> 19 <u>56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>
9. AGE (In years, last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ryan, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Scott Harris</u>		14. MOTHER'S MARDEN NAME <u>Carrie Henderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Roland J. Smith</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vas. Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Right Hemiplegia - 9 10 yrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1946</u> to <u>Sept. 29, 1956</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>1110-60" Ave</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. [Signature]</u> M.D.		DATE SIGNED <u>1001 Eastern Ave, NE</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>10-3-56</u>		22b. DATE THEREOF <u>10-3-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malcolm &amp; Ashley 424 R St NW</u>		24a. REC'D BY REGISTRAR <u>18 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>625</u>		(Filing No)	



CERTIFICATE OF DEATH

*[Faint, mostly illegible handwritten text on a death certificate form. Visible fragments include:]*

NAME: *[illegible]*  
AGE: *[illegible]*  
SEX: *[illegible]*  
RACE: *[illegible]*  
DATE OF BIRTH: *[illegible]*  
PLACE OF BIRTH: *[illegible]*  
DATE OF DEATH: *[illegible]*  
PLACE OF DEATH: *[illegible]*  
CAUSE OF DEATH: *[illegible]*  
MANNER OF DEATH: *[illegible]*  
SIGNATURE: *[illegible]*  
DATE: *[illegible]*

BUREAU V. S.

OCT 18 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND  
 Item 9 Film G204 9-19-56 et  
 9625  
 CERTIFICATE OF DEATH

69574

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 5761 First St. S.E.	
3. NAME OF DECEASED (Type or print) Ruby M. Harrison		4. DATE OF DEATH 9-9-1956	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/31/1896
9. AGE (In years last birthday) 64		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper		10b. KIND OF BUSINESS OR INDUSTRY Bakery Store	
11. BIRTH PLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Edward Suit		14. MOTHER'S MAIDEN NAME Lottie M. Watson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 578-05-8982	
17. INFORMANT Ethel Price (sister)		Address Princess Ann Md. R.R. 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from OCTOBER 1, 1955, to SEPT 7, 1956, that I last saw the deceased alive on September 7, 1956, and that death occurred at 11:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Victor H. Esch, M.D.		DATE SIGNED 9/10/56	
PHYSICIAN'S NAME (Type) VICTOR H. ESCH, M.D.		ADDRESS (Street, city or town, state) 3404 Wisconsin Ave N.W. Washington 16, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/12/56	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland Md.
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home, Inc. 3200 R. 2 Ave		24a. REC'D BY REGISTRAR DATE SEP 13 1956	24b. REGISTRAR'S SIGNATURE A. J. DeWick

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>Sept 12, 1956</i>		6. TIME OF DEATH <i>10:30 AM</i>	
7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. DISEASE OR INJURY <i>Myocardial Infarction</i>		10. MANNER OF DEATH <i>Natural</i>	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>	
15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>	
23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>	
27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>	
35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>	
39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>	
45. SIGNATURE OF WITNESS <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>	
47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>	
51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>	
53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>	
57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>	
59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>	
63. SIGNATURE OF WITNESS <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>	
65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>	
69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>	
71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>	
75. SIGNATURE OF WITNESS <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>	
77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF WITNESS <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>	
83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>	
87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>	
89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>	
93. SIGNATURE OF WITNESS <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>	
95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>	
99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

RECEIVED  
SEP 13 1956  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9626 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **09575**

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Camp Springs</b>				c. LENGTH OF STAY IN 1b <b>Transient</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>In a pond</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Springs</b> <b>15-56-2</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>PAUL</b> First <b>CARRINGTON</b> Middle <b>HART</b> Last				4. DATE OF DEATH Month <b>September</b> Day <b>1</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>21 May 1909</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Well Drilling Operator Col. Well Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Va.</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John H. Hart</b>				14. MOTHER'S MAIDEN NAME <b>Irene McGhee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WWII</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>MILDRED S. HART</b>				Address <b>Same as # 2 (Wife)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>929.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Drowning</b> (c) <b>Drowning</b> DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was wading in a pond and got stuck in the mud</b>			
20c. TIME OF INJURY Hour <b>9:30</b> a. m. <b>P.M.</b> Month, Day, Year <b>9/1/56</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>A pond</b>		20f. (City or town) (County) (State) <b>Camp Spring P.G. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James I. Boyd</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James I. Boyd, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>9/5/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Ceme.</b>	
				22d. LOCATION (City, town, or county) <b>Arlington, Va.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. GASCH'S SONS</b>				ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 7 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Carrie Campbell</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item PM3. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

1  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

Name of Deceased John H. Jones		Date of Death 10-10-1956	
Age 45		Sex Male	
Race White		Marital Status Married	
Usual Residence 1234 Main St., Baltimore, Md.		Cause of Death Heart Disease	
Immediate Cause Myocardial Infarction		Contributing Cause Hypertension	
Manner of Death Natural		Signature of Examiner [Signature]	
Date of Report 10-15-1956		Signature of Physician [Signature]	

BUREAU V. 3

SEP 7 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9585

CERTIFICATE OF DEATH

10576

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly, Md.</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hosp.</u>		e. STREET ADDRESS <u>1009 Addison Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Janis</u> Middle <u>Marlene</u> Last <u>Harvell</u>		4. DATE OF DEATH Month <u>September</u> Day <u>23</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 20, 1956</u>
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Louis Mathews</u>		14. MOTHER'S MAIDEN NAME <u>Amy Christine Harvell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mother -- as above.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>762.5</u> IMMEDIATE CAUSE (a) <u>atelectasi</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DUE TO</u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/20/56</u> , 19 <u>56</u> , to <u>9/23/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/23/56</u> , 19 <u>56</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Perkins</u> M.D.		ADDRESS (Street, city or town, state) <u>5301 Hamilton St. Hyattsville, Md.</u> DATE SIGNED <u>9/24/56</u>	
PHYSICIAN'S NAME (Type) <u>John W. Perkins</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 19 56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Georges Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cheverly Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Perkins</u> ADDRESS <u>2177 172nd St</u>		24a. REC'D BY REGISTRAR <u>22 56</u> DATE <u>Oct 22 56</u>	
24b. REGISTRAR'S SIGNATURE <u>Perkins</u>			

OCT 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10577

9586

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 30 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joyce Baby Darlene Middle "B" Last Harvell		4. DATE OF DEATH Month 20 Sept. 1956 Day 20 Year 1956	
5. SEX Female	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Sept. 1956
9. AGE (In years last birthday) yrs. 30		10. IF UNDER 1 YEAR Months Days Hours Min. 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Louis Matthews		14. MOTHER'S MAIDEN NAME Christine Harvell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mother		Address as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/20/56, 19, to 9/20/56, 19, that I last saw the deceased alive on 9/20/56, 19, and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Perkins M.D.		ADDRESS (Street, city or town, state) 5301 Harwell St. Hyattsville, Md.	
DATE SIGNED 9/21/56			
PHYSICIAN'S NAME (Type) John W. Perkins			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Oct 1956	
22c. NAME OF CEMETERY OR CREMATORY Prince Georges Cemetery		22d. LOCATION (City, town, or county) (State) Cheverly Md	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE OCT 22 '56	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

2277173XV6

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968	
AGE		SEX	
35		Male	
RACE		COLOR OF SKIN	
White		White	
EDUCATION		OCCUPATION	
High School		Author	
MARRIAGE		PLACE OF BIRTH	
Married		Memphis, Tennessee	
DATE OF MARRIAGE		PLACE OF DEATH	
1964		Memphis, Tennessee	
CAUSE OF DEATH		MANNER OF DEATH	
Suicide		Accident	
DETAILS OF DEATH		SIGNATURE OF PHYSICIAN	
Suicide by gunshot		[Signature]	
DATE OF EXAMINATION		SIGNATURE OF EXAMINER	
April 4, 1968		[Signature]	
PLACE OF EXAMINATION		SIGNATURE OF WITNESS	
Memphis, Tennessee		[Signature]	
DATE OF BURIAL		PLACE OF BURIAL	
April 8, 1968		Memphis, Tennessee	
NAME OF BURIAL PLACE		NAME OF FUNERAL HOME	
[Name]		[Name]	

BUREAU V. S.

OCT 22 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registry prior to burial, cremation, or removal.

9627 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69576

Reg. Dist. No.

234

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton	
c. LENGTH OF STAY IN 1b 6 months		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 35 Horseshoe Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 35 Horseshoe Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Gertrude Anne Hellman		4. DATE OF DEATH Month Day Year Sept 13 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4 1905
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Sew Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. C	
13. FATHER'S NAME Gustor Engle Infeld		14. MOTHER'S MAIDEN NAME Hoffman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT John Paul Hellman	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X DUE TO congestive heart failure (b) Rheumatic heart disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9-17-1956	
22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Ex. M. Yew. Va		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert M. Mattingly		24. REC'D BY REGISTRAR 25. REGISTRAR'S SIGNATURE Carrie Campbell	

MEDICAL CERTIFICATION

ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

9/13/56



BUREAU V. 8.

SEP 14 1956

RECEIVED

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9628  
CERTIFICATE OF DEATH

09577

Reg. Dist. No.

743

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2119 Chestnut ave</u>		d. STREET ADDRESS <u>2119 Chestnut ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Aloysius</u> Middle <u>Leroy</u> Last <u>Hemphill</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 6<sup>th</sup> 1890</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>SPIRIT LAKE, IOWA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEROY HEMPHILL</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET RYON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-26-8398</u>	
17. INFORMANT <u>Miss DOROTHY L. McNAHARA - Bowie Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Carcinoma of the Pancreas</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>approx 1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> 19 <u>52</u> to <u>Sept 23</u> 19 <u>56</u> , that I last saw the deceased alive on <u>9/22</u> 19 <u>56</u> , and that death occurred at <u>11:15</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. James Kurtz</u>		ADDRESS (Street, city or town, state) <u>P.F.D. Bowie Md</u>	
PHYSICIAN'S NAME (Type) <u>H. James Kurtz</u>		DATE SIGNED <u>9/23/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/28/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON NATL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>5417 LAND, R. COV. CO. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chamber Co - Spindale Md</u>		24a. REC'D BY REGISTRAR <u>SEP 28 1956</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>John H. Youngling</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-100

BUREAU V. 1

SEP 28 1956

RECEIVED

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>Sept 25, 1956</i>		6. TIME OF DEATH <i>11:00 AM</i>		7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. DISEASE OR INJURY <i>Myocardial Infarction</i>		10. MANNER OF DEATH <i>Natural</i>		11. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF DECEASED <i>John Doe</i>	
17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>		19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>	
21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF DECEASED <i>John Doe</i>		23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF DECEASED <i>John Doe</i>		27. SIGNATURE OF DECEASED <i>John Doe</i>		28. SIGNATURE OF DECEASED <i>John Doe</i>	
29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>		31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF DECEASED <i>John Doe</i>	
33. SIGNATURE OF DECEASED <i>John Doe</i>		34. SIGNATURE OF DECEASED <i>John Doe</i>		35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF DECEASED <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF DECEASED <i>John Doe</i>		39. SIGNATURE OF DECEASED <i>John Doe</i>		40. SIGNATURE OF DECEASED <i>John Doe</i>	
41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF DECEASED <i>John Doe</i>		43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF DECEASED <i>John Doe</i>	
45. SIGNATURE OF DECEASED <i>John Doe</i>		46. SIGNATURE OF DECEASED <i>John Doe</i>		47. SIGNATURE OF DECEASED <i>John Doe</i>		48. SIGNATURE OF DECEASED <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF DECEASED <i>John Doe</i>		51. SIGNATURE OF DECEASED <i>John Doe</i>		52. SIGNATURE OF DECEASED <i>John Doe</i>	
53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF DECEASED <i>John Doe</i>		55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF DECEASED <i>John Doe</i>	
57. SIGNATURE OF DECEASED <i>John Doe</i>		58. SIGNATURE OF DECEASED <i>John Doe</i>		59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF DECEASED <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF DECEASED <i>John Doe</i>		63. SIGNATURE OF DECEASED <i>John Doe</i>		64. SIGNATURE OF DECEASED <i>John Doe</i>	
65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF DECEASED <i>John Doe</i>		67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF DECEASED <i>John Doe</i>	
69. SIGNATURE OF DECEASED <i>John Doe</i>		70. SIGNATURE OF DECEASED <i>John Doe</i>		71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF DECEASED <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF DECEASED <i>John Doe</i>		75. SIGNATURE OF DECEASED <i>John Doe</i>		76. SIGNATURE OF DECEASED <i>John Doe</i>	
77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF DECEASED <i>John Doe</i>		79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF DECEASED <i>John Doe</i>	
81. SIGNATURE OF DECEASED <i>John Doe</i>		82. SIGNATURE OF DECEASED <i>John Doe</i>		83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF DECEASED <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF DECEASED <i>John Doe</i>		87. SIGNATURE OF DECEASED <i>John Doe</i>		88. SIGNATURE OF DECEASED <i>John Doe</i>	
89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>John Doe</i>		91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF DECEASED <i>John Doe</i>	
93. SIGNATURE OF DECEASED <i>John Doe</i>		94. SIGNATURE OF DECEASED <i>John Doe</i>		95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF DECEASED <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF DECEASED <i>John Doe</i>		99. SIGNATURE OF DECEASED <i>John Doe</i>		100. SIGNATURE OF DECEASED <i>John Doe</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09578

9559

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5609-29th AVENUE</u>		d. STREET ADDRESS <u>5609 29th Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>ISABELLE</u> Last <u>HIATT</u>		4. DATE OF DEATH Month <u>9</u> Day <u>11</u> Year <u>1956</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-20-73</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-44-7558</u>	
17. INFORMANT <u>Norman Hiatt</u> Address <u>5609 29th Ave. Hyattsville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>451X Acute dissecting aneurysm</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>aneurysm - abdominal aorta</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u> <u>10 yrs +</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>56</u> , to <u>Sept 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 11</u> , 19 <u>56</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Erwin Steinman</u> M.D.		DATE SIGNED <u>3520-14th ST. NW. Washington, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>ERWIN STEINMAN M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/14/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEM</u>		22d. LOCATION (City, town, or county) (State) <u>COUNTY MARYLAND PRINCE GEO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamber Co - Springfield, Md</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>Sept 14 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe Deputy</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 958 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09579  
231

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>5710 Euclid Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Sara</b> Last <b>Hodges</b>				4. DATE OF DEATH Month <b>September</b> Day <b>5</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-13-50</b>		9. AGE (In years last birthday) <b>6</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Victor Berger Hodges</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Mahaney</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mother, Same address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Spontaneous intrapontine hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Softening of dorsum of pons and medulla area</b> (c) <b>Softening of dorsum of pons and medulla area</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 10/1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Pr. Geo. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>				24a. REC'D BY REGISTRAR <b>SEP 10 1956</b>		24b. REGISTRAR'S SIGNATURE <b>H. H. Hedrick</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar (to burial, cremation, or removal).

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Princess George	
Sex		Male	
Age		2-13-20	
Race		White	
Place of Birth		Washington, D.C.	
Date of Birth		2-13-20	
Date of Death		2-13-20	
Place of Death		Princess George General Hospital	
Cause of Death		Spontaneous intracranial hemorrhage	
Manner of Death		Natural	
Signature of Examiner		Victor Barker Hodges	
Signature of Physician		Harold H. Hodges	
Signature of Coroner		John T. McManey, D.D.	

Spontaneous intracranial hemorrhage  
 Softening of dorsum of spine and vertebrae

**BUREAU A. 2**  
 SEP 10 1956  
**RECEIVED**

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

This Certificate approved by Dr. John T. Maloney, Dep. Med. Exam. Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9529

CERTIFICATE OF DEATH

09580

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seabrook</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seabrook</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Herbek</u> Last <u>Herbek</u>				4. DATE OF DEATH <u>Sept 24</u> Month <u>Sept</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 27, 1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tool and dye</u>			
11. BIRTHPLACE (State or foreign country) <u>Austria</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Anton Herbek</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>083-01-2223-A</u>			
17. INFORMANT <u>Josephine Judifind-Seabrook</u> Address <u>md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Dis.</u> DUE TO <u>14 mo</u> (c) <u>3 mo</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 10</u> , 19 <u>56</u> , to <u>Sept 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 8</u> , 19 <u>56</u> , and that death occurred at <u>5:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. W. Malini</u>				ADDRESS (Street, city or town, state) <u>Riversdale, Md</u> DATE SIGNED <u>9-24-56</u>			
PHYSICIAN'S NAME (Type) <u>L. W. Malini M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT 27, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BUDENBURG RD. P. GEORGE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Smith</u> ADDRESS <u>254 CARROLL ST NW</u>				24c. RECEIVED BY REGISTRAR DATE <u>SEP 28</u>			
				24b. REGISTRAR'S SIGNATURE <u>R. J. Smith</u>			

BUREAU V. S.

SEP 28 1956

RECEIVED

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
c. LENGTH OF STAY IN 1b 9 yrs., 8 mo's		d. STREET ADDRESS 2603 Sherman Ave., N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elmore Middle Roy (Sr.) Hunter Last		4. DATE OF DEATH Month Sept. Day 29 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1903
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary steam engnr.		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Powatan Hunter		14. MOTHER'S MAIDEN NAME Lillie Winbush	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-05-9113	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Toxemia DUE TO (c) Micrococcus Anerobius empyema, left			INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, 10 years, 8 months; lt. pneumonectomy,			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) 9/19/56	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/22/47, 19, to 9/29/56, that I last saw the deceased alive on 9/29/56, 19, and that death occurred at 4:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Daniel Leo Finucane		M.D. Glenn Dale Hospt., Glenn Dale, MD. 9/29/56	
PHYSICIAN'S NAME (Type) Daniel Leo Finucane			
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 9/30/56	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE 9/29/56	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9631

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09582

Reg. Dist. No.

741

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u>			
c. LENGTH OF STAY IN 1b <u>3 1/2 years</u>				d. STREET ADDRESS <u>5813-24th Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5813-24th Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ursula</u> Middle <u>Frances</u> Last <u>Hurney</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 9, 1900</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>56</u> Days <u>56</u>		IF UNDER 24 HRS. Hours <u>56</u> Min. <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>State Dept</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Edward Pardoe</u>				14. MOTHER'S MAIDEN NAME <u>Mary Gatt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Frances Burton, same as #1</u> Address <u>same as #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (a), stating the underlying cause last. DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u></u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10-1-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincolns</u>	
22d. LOCATION (City, town, or county) <u>Bladensburg Md.</u>				22e. (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>James I. Boyd</u> ADDRESS <u>1661-48th Ave Rd SE Wash. 20 D</u>				24a. REC'D BY REGISTRAR <u>OCT 1 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

OCT 1 1956

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9588**  
**CERTIFICATE OF DEATH**

09583

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <span style="float:right">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float:right">b. COUNTY <b>Prince George</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>1 1/2 hour</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				d. STREET ADDRESS <b>8651 Landover Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Francis</b> Middle <b>De Sales</b> Last <b>Jackson</b>				4. DATE OF DEATH Month <b>sept.</b> Day <b>17</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-13-84</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>James D. Jackson</b> Address <b>Suitland, Mc.</b>			
18. CAUSE OF DEATH [Enter only one cause per title for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary edema</b> <b>420.0</b> DUE TO <b>Arteriosclerosis of the heart &amp; failure.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/17</b> , 19 <b>56</b> , to <b>9/17</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9/17</b> , 19 <b>56</b> , and that death occurred at <b>3:45 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Gordon W. Kelley</b> M.D.				ADDRESS (Street, city or town, state) <b>6124-41st Ave Hyattsville Md</b>		DATE SIGNED <b>9/18/56</b>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/20/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bryantown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 21 '56</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 21 1956

BUREAU V. S.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9632 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09584

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmount Heights</b>		c. LENGTH OF STAY IN 1b <b>Transient</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5717 Jost St.</b>				d. STREET ADDRESS <b>1135 - C - St. N.E.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Claude Jerome Barker Johnson</b>				4. DATE OF DEATH Month Day Year <b>September 7 1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1902</b>		9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Huckster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Barker Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Anna E. Boston</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Catherine Henderson</b> Address <b>5717 Jost St. Fairmount Heights, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular renal disease</b> DUE TO (c) 442X							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-12-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Payne</b>		22d. LOCATION (City, town, or county) (State) <b>Wash. D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph Barbour, 48 K St., N.E., Washington, D.C.</b>				24a. REC'D BY REGISTRAR <b>SEP 11 1956</b>		24b. REGISTRAR'S SIGNATURE <b>R. H. Redick</b>	

MEDICAL CERTIFICATION

2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
William James Johnson		Male		35		1921	
Residence		Occupation		Cause of Death		Manner of Death	
1234 Main St., Baltimore, Md.		Carpenter		Heart failure		Natural	
Physician		Date of Death		Time of Death		Place of Death	
Dr. J. H. Smith		September 10, 1956		10:30 AM		Home	
Medical History		Social History		Family History		Post-mortem Examination	
Hypertension, Diabetes		Smoker, 20 years		None		None	
Previous Illnesses		Alcohol Consumption		Heredity		Autopsy	
None		Occasional		None		None	
Signs and Symptoms		Laboratory Examinations		X-ray		Other	
Chest pain, shortness of breath		Blood test, normal		Normal		None	
Death certificate signed by physician		Death certificate signed by medical examiner		Death certificate signed by coroner		Death certificate signed by judge	
[Signature]		[Signature]		[Signature]		[Signature]	

**BUREAU V. &**  
**RECEIVED**  
 SEP 11 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 09585

9589

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>3710 - 37th St.</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas</u> First <u>Johnson</u> Middle <u>-</u> Last		4. DATE OF DEATH <u>Sept.</u> Month <u>29</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/9/87</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet metal worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>navy yard</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Edward Ross Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Julia Rickett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Ethel V. Greene</u> Address <u>Washington 20 D.C.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hegato - renal failure</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Portal cirrhosis?</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/26</u> , 19 <u>56</u> , to <u>9/29</u> , 19 <u>56</u> that I last saw the deceased alive on <u>9/29</u> , 19 <u>56</u> , and that death occurred at <u>7:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Hans Wodak</u> M.D.		ADDRESS (Street, city or town, state) <u>30 C Bridge Rd, Greenbelt, Md</u> DATE SIGNED <u>9/29/56</u>	
PHYSICIAN'S NAME (Type) <u>HANS WODAK</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/2/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalleys Funeral Home, Mt Rainier, Md</u> ADDRESS		24a. REC'D BY REGISTRAR <u>OCT 2 '56</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur</u>

CERTIFICATE OF DEATH

PLACE IN BOX 1		PLACE IN BOX 2	
DATE OF DEATH		AGE	
SEX		RACE	
EDUCATION		OCCUPATION	
MARRIED		SINGLE	
WIDOW		DIVORCED	
PLACE IN BOX 3		PLACE IN BOX 4	
PLACE IN BOX 5		PLACE IN BOX 6	
PLACE IN BOX 7		PLACE IN BOX 8	
PLACE IN BOX 9		PLACE IN BOX 10	
PLACE IN BOX 11		PLACE IN BOX 12	
PLACE IN BOX 13		PLACE IN BOX 14	
PLACE IN BOX 15		PLACE IN BOX 16	
PLACE IN BOX 17		PLACE IN BOX 18	
PLACE IN BOX 19		PLACE IN BOX 20	
PLACE IN BOX 21		PLACE IN BOX 22	
PLACE IN BOX 23		PLACE IN BOX 24	
PLACE IN BOX 25		PLACE IN BOX 26	
PLACE IN BOX 27		PLACE IN BOX 28	
PLACE IN BOX 29		PLACE IN BOX 30	
PLACE IN BOX 31		PLACE IN BOX 32	
PLACE IN BOX 33		PLACE IN BOX 34	
PLACE IN BOX 35		PLACE IN BOX 36	
PLACE IN BOX 37		PLACE IN BOX 38	
PLACE IN BOX 39		PLACE IN BOX 40	
PLACE IN BOX 41		PLACE IN BOX 42	
PLACE IN BOX 43		PLACE IN BOX 44	
PLACE IN BOX 45		PLACE IN BOX 46	
PLACE IN BOX 47		PLACE IN BOX 48	
PLACE IN BOX 49		PLACE IN BOX 50	
PLACE IN BOX 51		PLACE IN BOX 52	
PLACE IN BOX 53		PLACE IN BOX 54	
PLACE IN BOX 55		PLACE IN BOX 56	
PLACE IN BOX 57		PLACE IN BOX 58	
PLACE IN BOX 59		PLACE IN BOX 60	
PLACE IN BOX 61		PLACE IN BOX 62	
PLACE IN BOX 63		PLACE IN BOX 64	
PLACE IN BOX 65		PLACE IN BOX 66	
PLACE IN BOX 67		PLACE IN BOX 68	
PLACE IN BOX 69		PLACE IN BOX 70	
PLACE IN BOX 71		PLACE IN BOX 72	
PLACE IN BOX 73		PLACE IN BOX 74	
PLACE IN BOX 75		PLACE IN BOX 76	
PLACE IN BOX 77		PLACE IN BOX 78	
PLACE IN BOX 79		PLACE IN BOX 80	
PLACE IN BOX 81		PLACE IN BOX 82	
PLACE IN BOX 83		PLACE IN BOX 84	
PLACE IN BOX 85		PLACE IN BOX 86	
PLACE IN BOX 87		PLACE IN BOX 88	
PLACE IN BOX 89		PLACE IN BOX 90	
PLACE IN BOX 91		PLACE IN BOX 92	
PLACE IN BOX 93		PLACE IN BOX 94	
PLACE IN BOX 95		PLACE IN BOX 96	
PLACE IN BOX 97		PLACE IN BOX 98	
PLACE IN BOX 99		PLACE IN BOX 100	

BUREAU V. 3

OCT 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9590 CERTIFICATE OF DEATH

09586

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) d. STATE <u>New York</u> b. COUNTY <u>Brooklyn</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES Hospital</u>				d. STREET ADDRESS <u>193 Quentin Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>KING</u> Last <u>KING</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>16 July 84</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Max Herschkorn</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Israel - (Riverdale, Md)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u></u>		17. INFORMANT <u>William King</u> Address <u>6119-43rd St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> 545X DUE TO <u>Post Operative Gastrectomy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>UREMIA, Inanition, ADRENAL Exhaustion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>13 days</u> <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12 Sep</u> , 19 <u>56</u> , to <u>27 Sep</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>26 Sep</u> , 19 <u>56</u> , and that death occurred at <u>3:20</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Bayly</u>		M.D. <u>1835</u>		ADDRESS (Street, city or town, state) <u>EYE AIN, WASH, DC</u>		DATE SIGNED <u>27 Sep 56</u>	
PHYSICIAN'S NAME (Type) <u>JOHN H. BAYLY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Queens, L.I. N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hayskyt Sons - wash, D.C.</u>				24a. REC'D BY REGISTRAR <u>OCT 2 '56</u>		24b. REGISTRAR'S SIGNATURE <u></u>	



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
James G. Jones		Male		45		1910		Maryland	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
10/1/56		Home		Heart Disease		Natural		Farmer	
TIME OF DEATH		HOURS		MINUTES		PERIOD OF ILLNESS		PREVIOUS ILLNESS	
10:00 AM		10		00		2 Weeks		None	
NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF NURSE		NAME OF MINISTER		NAME OF CHURCH	
Dr. J. H. Smith		St. Mary's Hospital		Mrs. J. H. Smith		Rev. J. H. Smith		St. Mary's Church	
SIGNATURE OF PHYSICIAN		SIGNATURE OF HOSPITAL		SIGNATURE OF NURSE		SIGNATURE OF MINISTER		SIGNATURE OF CHURCH	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE		CAUSE		MANNER	
10/1/56		10:00 AM		Home		Heart Disease		Natural	

BUREAU V. 2

OCT 2 1956

RECEIVED

9633

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Forestville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 3405-75th Ave.	
3. NAME OF DECEASED (Type or print) EARL		4. DATE OF DEATH SEPT 9 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 4, 1890
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Landers		14. MOTHER'S MAIDEN NAME Blough	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 192-016-657	
17. INFORMANT Geo. E. Landers		Address 3405-75th Ave. N. Forestville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.1 Congestive Heart Failure DUE TO (b) Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 days + 2 days +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 7, 1956, to Sept 9, 1956, that I last saw the deceased alive on Sept 7, 1956, and that death occurred at M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James C. Cawood		ADDRESS (Street, city or town, state) 2520 Paine A.E. DC 9/7/56	
PHYSICIAN'S NAME (Type) JAMES C. CAWOOD		WASHINGTON DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/13/56	
22c. NAME OF CEMETERY OR CREMATORY Custer Cemetery		22d. LOCATION (City, town, or county) (State) HOLSOPIE PA.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. S. Leo Son		ADDRESS Washington D.C.	
24a. REC'D BY REGISTRAR DATE 9/10-56		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for death certificate, including fields for name, date, cause of death, and location. The text is mostly illegible due to blurriness.

BUREAU V.

SEP 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09588

9634

## CERTIFICATE OF DEATH

Reg. Dist. No.

243

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Dist. of Col.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (RURAL)</b>				c. LENGTH OF STAY IN 1b <b>9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>				d. STREET ADDRESS <b>914 - 9th St., N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Lee</b> Last <b>Lee</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>30</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Chinese</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/11/1892</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months <b>63</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>China</b>	
13. FATHER'S NAME <b>Fong Mig</b>				14. MOTHER'S MAIDEN NAME <b>Yees</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>no</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Decedent</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic Heart Disease</b> DUE TO (c) <b>unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1) Diabetes mellitus, 14 yrs; Pulmonary tuberculosis, 3 yrs., 6 months</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 21, 1956</b> , to <b>Sept., 30, 1956</b> , that I last saw the deceased alive on <b>1/29/56</b> , 19 <b>56</b> , and that death occurred at <b>6:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Glenn Dale Hospital, Glenn Dale, Maryland</b> DATE SIGNED <b>9/30/56</b>							
ACTUAL SIGNATURE <b>Daniel Leo Finucane</b> M.D.				DATE SIGNED <b>9/30/56</b>			
PHYSICIAN'S NAME (Type) <b>Daniel Leo Finucane</b>							
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF <b>10-2-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>George Washington</b>		22d. LOCATION (City, town, or county) (State) <b>Hyattsville, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sons Co</b>				ADDRESS <b>300 - 4th St</b>		24a. REC'D BY REGISTRAR DATE <b>9/30/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Uwe Green</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
Clerical		High School		Married		Catholic		White		Caucasian		Brown		Blue	
Cause of Death		Immediate Cause		Underlying Cause		Contributing Cause		Manner of Death		Place of Death		Date of Death		Time of Death	
Myocardial Infarction		Coronary Atherosclerosis		Hypertension		Diabetes Mellitus		Natural		Home		JAN 10 1963		10:30 AM	
Physician's Signature		Physician's Name		Physician's Address		Physician's City		Physician's State		Physician's Country		Physician's License No.		Physician's Signature	
[Signature]		JAMES EARL RAY		1000 E. 10th St.		Baltimore		Maryland		USA		123456789		[Signature]	
Medical Examiner's Signature		Medical Examiner's Name		Medical Examiner's Address		Medical Examiner's City		Medical Examiner's State		Medical Examiner's Country		Medical Examiner's License No.		Medical Examiner's Signature	
[Signature]		JOHN DOE		123 Main St.		Baltimore		Maryland		USA		987654321		[Signature]	
Coroner's Signature		Coroner's Name		Coroner's Address		Coroner's City		Coroner's State		Coroner's Country		Coroner's License No.		Coroner's Signature	
[Signature]		JOHN DOE		123 Main St.		Baltimore		Maryland		USA		987654321		[Signature]	

RECEIVED  
BUREAU A. N.  
JAN 15 1963



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9591

## CERTIFICATE OF DEATH

Reg. Dist. No.

09589

245

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i> c. LENGTH OF STAY IN 1b <i>5 MO.</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Leland Memorial Hospital</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Prince Georges</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>5201 Edmonston Rd. Hyattsville, Md.</i> d. STREET ADDRESS <i>5201 Edmonston Rd</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Mattie H. Leedy</i>		4. DATE OF DEATH Month <i>9</i> Day <i>4</i> Year <i>1956</i>				
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 3 - 1875</i>	9. AGE (In years last birthday) <i>81</i> yrs.	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	IF UNDER 24 HRS. Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Charles Chapman</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Eastwood</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Hospital</i> Address <i>Chant.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>congestive heart failure</i> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <i>arteriosclerotic heart disease</i> DUE TO <i>general arteriosclerosis</i> (c) <i>undetermined</i>						INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>undetermined</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Aug 26, 1956</i> , to <i>Sept 4</i> , 1956, that I last saw the deceased alive on <i>Sept 4</i> , 1956, and that death occurred at <i>7:23</i> M, from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>L W Malen</i>		M.D. <i>Riverdale, Md.</i>		ADDRESS (Street, city or town, state) <i>9-4-56</i>		DATE SIGNED <i>9-4-56</i>
PHYSICIAN'S NAME (Type) <i>L W Malen</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-8-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mr. Pleasant Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Withsville White, Va.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch Sons</i>		ADDRESS <i>Hyattsville Md.</i>		24a. REC'D BY REGISTRAR <i>SEP 7 1956</i>		24b. REGISTRAR'S SIGNATURE <i>James Leacy</i>

CERTIFICATE OF DEATH

1956

Form with fields for Name, Sex, Age, Race, Date of Birth, Date of Death, Cause of Death, and other medical details. Includes handwritten entries such as "John B. Smith" and "Heart Disease".

BUREAU V. 1

SEP 7 1956

RECEIVED

Form with fields for Registrar, Date, and other administrative details. Includes handwritten entries such as "1-8-56" and "John B. Smith".

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **09590**

**9635**

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>University Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>University Park</b>	
c. LENGTH OF STAY IN 1b <b>15 Years</b>		d. STREET ADDRESS <b>4309 Sheridan Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4309 Sheridan St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>F.</b> Last <b>Luebner</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>24,</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 12, 1878</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gov't Printing</b>	
11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>Span-Amer.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Wife; Same address. Julia Luebner</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO (b) <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (c) <b>442K</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>442K</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>p. m.</b> <b>19</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>9-24-56</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/27/1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co., Riverdale, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 28 1956</b>	
		24b. REGISTRAR'S SIGNATURE <b>A. T. Hedrick</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. Malone, Jr.	
Age		35 years	
Sex		Male	
Race		White	
Date of Death		November 12, 1956	
Place of Death		Home	
Cause of Death		Acute correlative heart failure	
Contributing Cause		Hypertension	
Signature of Examiner		[Signature]	
Signature of Physician		[Signature]	

**BUREAU V. 2**  
 RECEIVED  
 SEP 28 1956

## MARYLAND STATE DEPARTMENT OF HEALTH

09591

2411 N. Charles Street, Baltimore

9560

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH COUNTY <u>Hyattsville Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Pr. Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
TOWN <u>Hyattsville</u>		TOWN <u>Hyattsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>5413 - Sargeant Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>FRANK</u> (First) <u>DUEBERRY</u> (Middle) <u>LUTTRELL</u> (Last) <u>SR.</u>		4. DATE OF DEATH <u>Sept. 19</u> 19 <u>56</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 13, 1868</u>
9. AGE last birthday <u>87</u> yrs.		10. AGE under 1 year <u>19</u> Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - fire watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Golden Country Inn</u>	
11. BIRTHPLACE (State or foreign country) <u>Robley, Va. (Richmond Co.)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Luttrell</u>		14. MOTHER'S MAIDEN NAME <u>Whelminia Hawks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>5413 - Sargeant Rd. Hyattsville, Md.</u>	
17. INFORMANT AND ADDRESS <u>Frank D. Luttrell, Jr.</u>		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420. Immediate cause	(a) <u>Coronary thrombosis with occlusion</u>	INTERVAL BETWEEN ONSET AND DEATH <u>about 2 days</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Coronary arterio-sclerosis</u>	<u>7</u>
	(c) <u>acute gall bladder</u>	<u>about 3 days</u>

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/17/, 1956, to 9/19/, 1956, that I last saw the deceased alive on 9/18/, 1956, and that death occurred at 9:00 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>9/19/56</u>	<u>OLD FARM HAM BAY CH.</u>	<u>ROBLEY, VA.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Sept. 19, 1956</u>	<u>James Dever</u>	<u>John T. Ryan, Inc.</u>	<u>317 Pa. Ave., S.E.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



RECEIVED

SEP 24 1956

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial-transit permit or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9592 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09592

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hosp.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 47x-3	
f. STREET ADDRESS <b>1121 Park Place, N.E.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>L</b> Last <b>Maddox</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>6</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 10, '91</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>26</b>	11. IF UNDER 24 HRS. Hours <b>26</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>P.R.R.</b>	
11. BIRTHPLACE (State or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George E. Maddox</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Mouney</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W.W.I</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Maude A. Maddox</b>		Address <b>1121 Park S t. N. E.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thrombosis of Iliac veins</b> DUE TO (c) <b>Injury to cervical cord</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell into pit while at work</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>8-13-56</b> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Pa. R.R. Yard</b> 20f. (City or town) <b>Washington, D.C.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John T. Maloney</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Sept. 6, 1956</b>	
22a. BURIAL, CREMATION, ETC. DATE THEREOF REMOVAL (Specify) <b>Burial Sept 10, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Georgetown</b>	
22b. FUNERAL DIRECTOR'S SIGNATURE <b>J. Williams</b>		22d. LOCATION (City, town, or county) <b>Smithland</b> (State) <b>Pa</b>	
23. ADDRESS <b>300 4th St. N.E.</b>		24a. REC'D BY REGISTRAR <b>H. K. Hedrick</b> 24b. REGISTRAR'S SIGNATURE <b>H. K. Hedrick</b>	

SEP 10 1956

District Coroner notified

SEP 10 1956

BUREAU V. I.

RECEIVED

MEDICAL CERTIFICATION

VS A1S (4)  
15M 9/55

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09594

Reg. Dist. No.

242

9636

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>Johnson</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferestville</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithfield</u> 70X-3		d. STREET ADDRESS <u>Market Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sansbury Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>M</u> Last <u>McClean</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coun Home</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>THOMAS M. McCLEAN, same as #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Con gestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-4-56</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Washington, D.C.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frazier's Funeral Home</u>				ADDRESS <u>389</u>		24b. REGISTRAR'S SIGNATURE <u>Carie Campbell</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED SEX AGE DATE OF BIRTH		PLACE OF BIRTH OCCUPATION	
DATE OF DEATH TIME OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH MANNER OF DEATH		MEDICAL HISTORY PRESENT ILLNESS	
SIGNATURE OF EXAMINER TITLE		SIGNATURE OF WITNESS TITLE	

**RECEIVED**  
 SEP 7 1956  
 BUREAU V. S.

MAILED 11 3 AM

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

9561

2411 N. Charles St., Baltimore

09595

## CERTIFICATE OF DEATH

Item 8 FilmG205 10-29-56 et

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County Prince GeorgeCity or town Hyattsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

at home

## 3. (a) FULL NAME

Helen Anne Moore

## 3. (b) Social Security Number

no

4. Sex

FM

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife

Joseph E. Moore

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

11-16-1887

8. AGE:

68

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Culpeper Va  
(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

at home

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal) Which?

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

no

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 26, 1956 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 301955to Sept. 26,1956

and that I last saw her

or

alive on

August 25,1956

Immediate cause of death

Myocardial infarct

DURATION

sudden

Due to

Hypertensive-arteriosclerotic heart disease10 yrs.

Due to

Other conditions

Diabetes mellitus,5 yrs. +Hemiplegia (cerebral apoplexy)8 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

---

Date of op.

Autopsy results

---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

2503 Queens Chapel Rd.,  
Mt. Rainier, Md.

M. D. or other

Date signed 9/26/56

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF BURIAL OFFICIAL

14. SIGNATURE OF VENDOR

15. SIGNATURE OF OTHER

16. SIGNATURE OF OTHER

17. SIGNATURE OF OTHER

18. SIGNATURE OF OTHER

19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

28. SIGNATURE OF OTHER

29. SIGNATURE OF OTHER

30. SIGNATURE OF OTHER

31. SIGNATURE OF OTHER

32. SIGNATURE OF OTHER

33. SIGNATURE OF OTHER

34. SIGNATURE OF OTHER

35. SIGNATURE OF OTHER

36. SIGNATURE OF OTHER

37. SIGNATURE OF OTHER

38. SIGNATURE OF OTHER

39. SIGNATURE OF OTHER

40. SIGNATURE OF OTHER

41. SIGNATURE OF OTHER

42. SIGNATURE OF OTHER

43. SIGNATURE OF OTHER

44. SIGNATURE OF OTHER

45. SIGNATURE OF OTHER

46. SIGNATURE OF OTHER

47. SIGNATURE OF OTHER

48. SIGNATURE OF OTHER

49. SIGNATURE OF OTHER

50. SIGNATURE OF OTHER

51. SIGNATURE OF OTHER

52. SIGNATURE OF OTHER

53. SIGNATURE OF OTHER

54. SIGNATURE OF OTHER

55. SIGNATURE OF OTHER

56. SIGNATURE OF OTHER

57. SIGNATURE OF OTHER

58. SIGNATURE OF OTHER

59. SIGNATURE OF OTHER

60. SIGNATURE OF OTHER

BUREAU V. S.

OCT 1 1956

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9562 CERTIFICATE OF DEATH

Reg. Dist. No. 09596

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) Paint Branch Hospital				d. STREET ADDRESS 5777 4th Place			
3. NAME OF DECEASED (Type or print) First Anna, Middle Mullin, Last				4. DATE OF DEATH Sept. 22, 1956			
5. SEX Fe		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 5, 1891	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Iowa	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Daniel M. Mullin				14. MOTHER'S MAIDEN NAME Mary Deane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Patient as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 196X Chondroma, Cervical Spine DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 16, 1956, to Sept 22, 1956, that I last saw the deceased alive on Sept 22, 1956, and that death occurred at 7:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE J. M. Whipple				M.D. J. M. Whipple			
PHYSICIAN'S NAME (Type) J. M. Whipple							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Transportation 9/23/56		22c. NAME OF CEMETERY OR CREMATORY Sheldon		22d. LOCATION (City, town, or county) (State) Iowa	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR DATE SEP 25 1956		24b. REGISTRAR'S SIGNATURE James Leary	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

89597

9594

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md.</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>8112-51st Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Alice</u> First <u>Nickens</u> Middle Last		4. DATE OF DEATH <u>Sept. 24</u> 19 <u>56</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Fenton Baltimore</u>		14. MOTHER'S/MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Elie White</u> Address <u>3112 51st St College Pk. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO (b) <u>with acute congestive failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Generalized Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>6:47</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>9/25/56</u>			
ACTUAL SIGNATURE <u>William Brainin</u> M.D.		PHYSICIAN'S NAME (Type) <u>WILLIAM BRAININ</u> Capital Hlth Md	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9-28-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Harmony</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Washington &amp; Sons</u> ADDRESS <u>467 N ST. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 26 56</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur Smith</u>

RECEIVED  
SEP 26 1956  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10605

9595

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colmar Manor</u>	
c. LENGTH OF STAY IN 16 <u>3 days</u>		d. STREET ADDRESS <u>4333 Lawrence St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Norriss</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>22</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 Sept. 1956</u>
9. AGE (In years last birthday) yrs. <u>3</u>		10. AGE (In years last birthday) yrs. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John Harper Norriss</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Jeanette Denning</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT <u>Mother - as above</u>		Address <u>                    </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> (c) <u>                    </u>		INTERVAL BETWEEN ONSET AND DEATH <u>                    </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>                    </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>                    </u> p. m. <u>                    </u> 19 <u>56</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <u>                    </u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>                    </u>		20f. (City or town) (County) (State) <u>                    </u>	
21. I certify that I attended the deceased from <u>9/19/56</u> , to <u>9/22/56</u> , that I last saw the deceased alive on <u>9/22/56</u> , and that death occurred at <u>2:56 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Perkins</u>		DATE SIGNED <u>9/24/56</u>	
PHYSICIAN'S NAME (Type) <u>John W. Perkins</u>		ADDRESS (Street, city or town, state) <u>Hyattsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Burial Home</u>		22d. LOCATION (City, town, or county) (State) <u>Cheverly Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry John W. Perkins</u>		ADDRESS <u>                    </u>	
24a. REC'D BY REGISTRAR <u>                    </u>		24b. REGISTRAR'S SIGNATURE <u>                    </u>	
DATE <u>Oct 22 56</u>		DATE <u>                    </u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		SEX		RACE		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE	
JAMES EARL RAY		APRIL 14, 1928		MALE		WHITE		MARRIED		HIGH SCHOOL		CLOCK REPAIRER		MEMPHIS, TENN.	
PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT	
MEMPHIS, TENN.		APRIL 4, 1968		4:00 PM		HEART DISEASE		SUICIDE		MEMPHIS, TENN.		APRIL 6, 1968		MEMPHIS, TENN.	
DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		DATE OF INTERMENT	
APRIL 4, 1968		4:00 PM		HEART DISEASE		SUICIDE		MEMPHIS, TENN.		APRIL 6, 1968		MEMPHIS, TENN.		APRIL 6, 1968	
DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		DATE OF INTERMENT	
APRIL 4, 1968		4:00 PM		HEART DISEASE		SUICIDE		MEMPHIS, TENN.		APRIL 6, 1968		MEMPHIS, TENN.		APRIL 6, 1968	

RECEIVED  
OCT 22 1956  
BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9637

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09598

Reg. Dist. No.

Y37

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>T. B.</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>T. B.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hurley's Bar</u>				d. STREET ADDRESS <u>Hurley's Bar</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Edward Parkman</u>				4. DATE OF DEATH Month Day Year <u>Sept 3 1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 24, 1914</u>	9. AGE (In years last birthday) <u>40 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant/Grocery Food</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Georgia</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>Feslight Parkman</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>252-38-793</u>		17. INFORMANT Address <u>Ellen S. Parkman Same as #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alcoholism</u> 322.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James T. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES T. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Sept 3, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/6/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Columbia Manor Rd Goo Co, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamber Co. 517-11 ST SE WASH DC</u>				24a. REC'D BY REGISTRAR <u>SEP 5 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John F. Danvers</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

SEP 5 1956

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9596 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **9596**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Memorial Hospital</b>				d. STREET ADDRESS <b>7400 Glenbrook Road</b>		15X-2	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Joseph</b> First <b>Politz</b> Middle Last				<b>4. DATE OF DEATH</b> Month <b>September</b> Day <b>7,</b> Year <b>19 56</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Jan. 5th, 1912</b>	
<b>9. AGE</b> (In years last birthday) <b>44</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Months Days Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Salesman</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Clothing</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Pennsylvania</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Barney Lewis Politz</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <input checked="" type="checkbox"/> (If yes, give war or dates of service) <b>W.W. 2</b>		<b>16. SOCIAL SECURITY NO.</b> <b>577-18-9941</b>		<b>17. INFORMANT</b> Address <b>Mollie Dicker, 7400 Glenbrook Road, Bethesda.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO (b) <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>John T. Maloney</i> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <b>Sept. 8, 1956</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>Sept. 11, 1956</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington Nat. Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Arlington, Virginia</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>B. Danzansky</i>				<b>24a. REC'D BY REGISTRAR</b> <b>24b. REGISTRAR'S SIGNATURE</b> <b>DATE</b> <b>Sept 12 1956</b> <i>Mrs. Jas. Sorese</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
 PHYSICIAN'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John T. Maloney		Male		45	
Date of Death		Place of Death		Cause of Death	
September 14, 1956		Home		Coronary artery disease	
Physician's Name		Physician's Address		Physician's Signature	
Dr. J. H. Smith		1000 Glenbrook Road, Baltimore, Md.		[Signature]	
Manner of Death		Place of Burial		Burial Date	
Natural		Catholic Cemetery		September 15, 1956	
Signature of Registrar		Signature of Physician		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

RECEIVED  
 SEP 14 1956  
 BUREAU V. 2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09600

Reg. Dist. No. 242

9638

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fort Washington and Warburton Roads		d. STREET ADDRESS 621 Condon Terrace S.E.	
3. NAME OF DECEASED (Type or print) First Sharon Middle Fay Last Raftery		4. DATE OF DEATH Month Sept. 25, 1956 Day 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1942
9. AGE (In years last birthday) 13 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph M.P. Raftery		14. MOTHER'S MAIDEN NAME Helen Duley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father		Address Same as #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 823x DUE TO Conditions, if any, which gave rise to immediate cause (b) Compound fracture of the skull, Crishech chest and abdomen (a), stating the underlying cause lost. DUE TO multiple fractures of the extremities (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of an automobile that ran off the road and struck a fixed object	
20c. TIME OF INJURY Month, Day, Year Hour 9:15 P.M. 9/ 25 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) (County) (State) Fort Washington P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd M.D.		DATE SIGNED September 26, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee's Sms 300-4778		24. REC'D BY REGISTRAR DATE 9-28-56	
24b. REGISTRAR'S SIGNATURE Carrie Campbell			



# STATE OF NEW YORK DEPARTMENT OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John J. Lafferty	
Sex		Male	
Race		White	
Age		30.11.1912	
Date of Birth		1912.11.30	
Place of Birth		New York City	
Usual Residence		New York City	
Cause of Death		Hepatic failure and shock	
Manner of Death		Natural causes	
Signature of Medical Examiner		James J. Boyd	
Date		October 2, 1956	

BUREAU V. 2

OCT 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G204 9-19-56 et

9597

CERTIFICATE OF DEATH

09601

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>2 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u> <u>16</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				d. STREET ADDRESS <u>3804 35th Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Anthony</u> Middle <u>Ramagnano</u> Last <u>Ramagnano</u>				<b>4. DATE OF DEATH</b> Month <u>Sept</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 Sept 1905</u>		9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Taxi</u>		11. BIRTHPLACE (State or foreign country) <u>Balt, more, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Anthony Ramagnano</u>				14. MOTHER'S MAIDEN NAME <u>Sophie Bruno</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary Ramagnano</u> Address <u>3804-35th St.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>CORONARY THROMBOSIS</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>51</u> , to <u>Sept 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 9</u> , 19 <u>56</u> , and that death occurred at <u>12:40</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donat Bureau</u>				ADDRESS (Street, city or town, state) <u>3503 Bwy St Mt Rainier Md</u> DATE SIGNED <u>9/9/56</u>			
PHYSICIAN'S NAME (Type) <u>Norman Donat Bureau</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, DC.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malley's Funeral Home, Mt. Rainier, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>SEP 13 '56</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MASSACHUSETTS		MALE		35		JAN 15 1921		BOSTON		MASSACHUSETTS		MASSACHUSETTS		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE	
JAN 15 1956		BOSTON		HEART DISEASE		NATURAL		CLERK		HIGH SCHOOL		CATHOLIC		MARRIED	
DATE OF INTERVIEW		PLACE OF INTERVIEW		NAME OF INTERVIEWER		SIGNATURE OF INTERVIEWER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	
JAN 15 1956		BOSTON		J. J. JONES		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE	
JAN 15 1956		BOSTON		HEART DISEASE		NATURAL		CLERK		HIGH SCHOOL		CATHOLIC		MARRIED	
DATE OF INTERVIEW		PLACE OF INTERVIEW		NAME OF INTERVIEWER		SIGNATURE OF INTERVIEWER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	
JAN 15 1956		BOSTON		J. J. JONES		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

SEP 13 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09602	
Item 18 Film G204 9-28-56										Reg. Dist. No. 730	
9558 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>			c. LENGTH OF STAY IN 1b <b>Transient</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dr. Mendel's Office</b>					d. STREET ADDRESS <b>University of Maryland</b>						
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Salvatore</b> Last <b>Restivo</b>					4. DATE OF DEATH Month <b>Sept.</b> Day <b>6,</b> Year <b>19 56</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 5, 1956</b>		9. AGE (In years last birthday) yrs. <b>1</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Frank Salvatore Restivo</b>					14. MOTHER'S MAIDEN NAME <b>Nancy Williams</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Father,</b>			Address <b>Same address.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>493 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Septal pneumonitis</b> DUE TO (c) <b>1</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John T. Maloney</b> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Sept. 7, 1956</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF <b>9/8/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>			22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch Sons</b>					ADDRESS <b>H. Gattaville</b>		24a. REC'D BY REGISTRAR <b>13 1956</b>		24b. REGISTRAR'S SIGNATURE <b>John D. Smith</b>		

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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University of Maryland

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University of Maryland

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BUREAU V. S.

SEP 13 1956

RECEIVED



9563

## CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheatonsville Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheatonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5401 38 Ave. Apt #2</u>		d. STREET ADDRESS <u>5401 - 38 Ave. Apt #2</u>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>G</u> Last <u>SATTELL</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>4</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/26/1898</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph DURNBAUGH</u>		14. MOTHER'S MAIDEN NAME <u>Barnes E. Bain</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Andrew N. ZWISLOCK</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Infarction</u> 430.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-24</u> , 1956, to <u>Sept 4</u> , 1956, that I last saw the deceased alive on <u>Sept 4</u> , 1956, and that death occurred at <u>8:20</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George J. Hagen</u>		ADDRESS (Street, city or town, state) <u>3717-38th Ave</u>	
PHYSICIAN'S NAME (Type) <u>George J. Hagen</u>		DATE SIGNED <u>9/4/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Sept. 6 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sees Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee's Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Sept 6 1956</u>	
ADDRESS <u>300-48th St. N.E. A.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Jas. Severe</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED [Faint, illegible text]		SEX [Faint, illegible text]		AGE [Faint, illegible text]	
PLACE OF BIRTH [Faint, illegible text]		DATE OF BIRTH [Faint, illegible text]		PLACE OF DEATH [Faint, illegible text]	
OCCUPATION [Faint, illegible text]		CAUSE OF DEATH [Faint, illegible text]		MANNER OF DEATH [Faint, illegible text]	
DATE OF DEATH [Faint, illegible text]		TIME OF DEATH [Faint, illegible text]		PLACE OF INTERMENT [Faint, illegible text]	
SIGNATURE OF DECEASED [Faint, illegible text]		SIGNATURE OF WITNESSES [Faint, illegible text]		SIGNATURE OF PHYSICIAN [Faint, illegible text]	
SIGNATURE OF CLERK [Faint, illegible text]		SIGNATURE OF REGISTRAR [Faint, illegible text]		SIGNATURE OF JUDGE [Faint, illegible text]	

BUREAU V. 1

SEP 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 10a, 11, 13, 14 FilmG202 9-13-56 et

9598  
CERTIFICATE OF DEATH

Reg. Dist. No. 89604 231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen. Hosp		d. STREET ADDRESS 4325 N. HAMP. Ave. NW	
3. NAME OF DECEASED (Type or print) MARY T. St. Clair		4. DATE OF DEATH Sept 1 1956	
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-5-85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME - - - Sullivan		14. MOTHER'S MAIDEN NAME Hannah Fuller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 142.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Epidermoid Carcinoma of Parotid Gland 2 YEARS (c)		INTERVAL BETWEEN ONSET AND DEATH hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 8/23, 1956, to 9/1, 1956, that I last saw the deceased alive on 9/1, 1956, and that death occurred at 6:15 A.M. from the causes and on the date stated above.		
ACTUAL SIGNATURE Saul Schwartz M.D. 5426-27 St. NW Wash. D.C. 9-1-56		DATE SIGNED
PHYSICIAN'S NAME (Type) SAUL SCHWARTZBACH		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 9-5-56	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Circle, Suitland Md.
22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Haulon 381 2nd St. SE		24a. REC'D BY REGISTRAR DATE SEP 10 1956
		24b. REGISTRAR'S SIGNATURE M. H. Hedrick

BUREAU V.

SEP 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7, 11, 10a, 13, 14 Film G205 10-11-56 et

9599

CERTIFICATE OF DEATH

09605

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHAPEL OAKS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp</u>		d. STREET ADDRESS <u>5900 Sheriff Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>FRANKES</u> Middle <u>E.</u> Last <u>SCAGGS</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>21</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-95</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New Glasgow, Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Rose</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage due to</u> <u>331X</u> DUE TO <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Intestinal hemorrhage due to U.C.</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>8/18, 1956</u> , to <u>9/21, 1956</u> , that I last saw the deceased alive on <u>9-21-56</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>John T. Horton</u>		DATE SIGNED <u>9/21/56</u>
PHYSICIAN'S NAME (Type) <u>John T. Horton</u>		ADDRESS (Street, city or town, state) <u>5241 St. Barnabas Rd SE</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/29/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woolman</u>
22d. LOCATION (City, town, or county) <u>Wash. DC.</u>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.N. Horton Co.</u>		ADDRESS <u>1322 4th St NW</u>
24a. REC'D BY REGISTRAR <u>9/21/56</u>		24b. REGISTRAR'S SIGNATURE <u>Quinn</u>



# CERTIFICATE OF DEATH

Form No. 100-10

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF DEATH [REDACTED]		5. TIME OF DEATH [REDACTED]		6. PLACE OF DEATH [REDACTED]	
7. CAUSE OF DEATH [REDACTED]		8. MANNER OF DEATH [REDACTED]		9. SIGNATURE OF DECEASED [REDACTED]	
10. SIGNATURE OF NEXT OF KIN [REDACTED]		11. SIGNATURE OF PHYSICIAN [REDACTED]		12. SIGNATURE OF MINISTER OF RELIGION [REDACTED]	
13. SIGNATURE OF CORONER [REDACTED]		14. SIGNATURE OF JURY [REDACTED]		15. SIGNATURE OF JUDGE [REDACTED]	
16. SIGNATURE OF CLERK [REDACTED]		17. SIGNATURE OF REGISTRAR [REDACTED]		18. SIGNATURE OF VENDOR [REDACTED]	
19. SIGNATURE OF WITNESS [REDACTED]		20. SIGNATURE OF WITNESS [REDACTED]		21. SIGNATURE OF WITNESS [REDACTED]	
22. SIGNATURE OF WITNESS [REDACTED]		23. SIGNATURE OF WITNESS [REDACTED]		24. SIGNATURE OF WITNESS [REDACTED]	
25. SIGNATURE OF WITNESS [REDACTED]		26. SIGNATURE OF WITNESS [REDACTED]		27. SIGNATURE OF WITNESS [REDACTED]	
28. SIGNATURE OF WITNESS [REDACTED]		29. SIGNATURE OF WITNESS [REDACTED]		30. SIGNATURE OF WITNESS [REDACTED]	
31. SIGNATURE OF WITNESS [REDACTED]		32. SIGNATURE OF WITNESS [REDACTED]		33. SIGNATURE OF WITNESS [REDACTED]	
34. SIGNATURE OF WITNESS [REDACTED]		35. SIGNATURE OF WITNESS [REDACTED]		36. SIGNATURE OF WITNESS [REDACTED]	
37. SIGNATURE OF WITNESS [REDACTED]		38. SIGNATURE OF WITNESS [REDACTED]		39. SIGNATURE OF WITNESS [REDACTED]	
40. SIGNATURE OF WITNESS [REDACTED]		41. SIGNATURE OF WITNESS [REDACTED]		42. SIGNATURE OF WITNESS [REDACTED]	
43. SIGNATURE OF WITNESS [REDACTED]		44. SIGNATURE OF WITNESS [REDACTED]		45. SIGNATURE OF WITNESS [REDACTED]	
46. SIGNATURE OF WITNESS [REDACTED]		47. SIGNATURE OF WITNESS [REDACTED]		48. SIGNATURE OF WITNESS [REDACTED]	
49. SIGNATURE OF WITNESS [REDACTED]		50. SIGNATURE OF WITNESS [REDACTED]		51. SIGNATURE OF WITNESS [REDACTED]	
52. SIGNATURE OF WITNESS [REDACTED]		53. SIGNATURE OF WITNESS [REDACTED]		54. SIGNATURE OF WITNESS [REDACTED]	
55. SIGNATURE OF WITNESS [REDACTED]		56. SIGNATURE OF WITNESS [REDACTED]		57. SIGNATURE OF WITNESS [REDACTED]	
58. SIGNATURE OF WITNESS [REDACTED]		59. SIGNATURE OF WITNESS [REDACTED]		60. SIGNATURE OF WITNESS [REDACTED]	
61. SIGNATURE OF WITNESS [REDACTED]		62. SIGNATURE OF WITNESS [REDACTED]		63. SIGNATURE OF WITNESS [REDACTED]	
64. SIGNATURE OF WITNESS [REDACTED]		65. SIGNATURE OF WITNESS [REDACTED]		66. SIGNATURE OF WITNESS [REDACTED]	
67. SIGNATURE OF WITNESS [REDACTED]		68. SIGNATURE OF WITNESS [REDACTED]		69. SIGNATURE OF WITNESS [REDACTED]	
70. SIGNATURE OF WITNESS [REDACTED]		71. SIGNATURE OF WITNESS [REDACTED]		72. SIGNATURE OF WITNESS [REDACTED]	
73. SIGNATURE OF WITNESS [REDACTED]		74. SIGNATURE OF WITNESS [REDACTED]		75. SIGNATURE OF WITNESS [REDACTED]	
76. SIGNATURE OF WITNESS [REDACTED]		77. SIGNATURE OF WITNESS [REDACTED]		78. SIGNATURE OF WITNESS [REDACTED]	
79. SIGNATURE OF WITNESS [REDACTED]		80. SIGNATURE OF WITNESS [REDACTED]		81. SIGNATURE OF WITNESS [REDACTED]	
82. SIGNATURE OF WITNESS [REDACTED]		83. SIGNATURE OF WITNESS [REDACTED]		84. SIGNATURE OF WITNESS [REDACTED]	
85. SIGNATURE OF WITNESS [REDACTED]		86. SIGNATURE OF WITNESS [REDACTED]		87. SIGNATURE OF WITNESS [REDACTED]	
88. SIGNATURE OF WITNESS [REDACTED]		89. SIGNATURE OF WITNESS [REDACTED]		90. SIGNATURE OF WITNESS [REDACTED]	
91. SIGNATURE OF WITNESS [REDACTED]		92. SIGNATURE OF WITNESS [REDACTED]		93. SIGNATURE OF WITNESS [REDACTED]	
94. SIGNATURE OF WITNESS [REDACTED]		95. SIGNATURE OF WITNESS [REDACTED]		96. SIGNATURE OF WITNESS [REDACTED]	
97. SIGNATURE OF WITNESS [REDACTED]		98. SIGNATURE OF WITNESS [REDACTED]		99. SIGNATURE OF WITNESS [REDACTED]	
100. SIGNATURE OF WITNESS [REDACTED]		101. SIGNATURE OF WITNESS [REDACTED]		102. SIGNATURE OF WITNESS [REDACTED]	

BUREAU V. S.

OCT 1 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9569 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89606

Reg. Dist. No.

773

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>			c. LENGTH OF STAY IN 1b <b>Transient</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1110 Kingwood Drive</b>				d. STREET ADDRESS <b>6506 North Point Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Grace</b> Middle <b>Seitz</b> Last <b>Seitz</b>				<b>4. DATE OF DEATH</b> Month <b>September</b> Day <b>12</b> Year <b>19 56</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Feb. 21st, 1890</b>		<b>9. AGE</b> (In years last birthday) <b>66</b> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Maryland</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>U.S.A.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Leo Killmeyer</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Newyler</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Sophia Hintz; Baltimore, Maryland.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive cardiovascular disease</b> (c) <b>DUE TO</b> (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <b>John T. Maloney</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <b>September 12, 1956</b>	
<b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>				<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>			
<b>22b. DATE THEREOF</b> <b>Sept. 15, 1956</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Belair Memorial Gardens</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Belair, Maryland</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>William Cook, Inc.</b>				<b>ADDRESS</b> <b>1217 St. Paul Street</b>		<b>24a. REC'D BY REGISTRAR</b> <b>SEP 17 1956</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <b>J. Wilson</b>				<b>24c. REGISTRAR'S SIGNATURE</b> <b>J. Wilson</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

SEP 17 1956

RECEIVED

John T. Maloney, M.D.

Name of Deceased		Sex		Age		Date of Death	
John T. Maloney		Male		45		September 17, 1956	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Boston, Mass.		Boston, Mass.		Coronary Atherosclerosis		Natural	
Occupation		Education		Previous Illnesses		Previous Operations	
Physician		High School		Hypertension		None	
Signature of Physician		Signature of Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	

9639

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White House Hgts</u>		c. LENGTH OF STAY IN 1b <u>13 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White House Hgts.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Warren + Electric Ave.</u>				d. STREET ADDRESS <u>Warren + Electric Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Virginia</u> Last <u>SELBA</u>				4. DATE OF DEATH Month <u>9</u> - Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-28-1900</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter A. Watson</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Clarence R. Selba</u> Address <u>Warren + Electric Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinomatosis</u> DUE TO (c) <u>Carcinoma of the uterus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 year</u> <u>4 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 1953</u> to <u>Sept 25, 1956</u> , that I last saw the deceased alive on <u>Sept 22, 1956</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. James Kutz</u> M.D.				ADDRESS (Street, city or town, state) <u>RFD Bowie Md</u> DATE SIGNED <u>9/25/56</u>			
PHYSICIAN'S NAME (Type) <u>H. James KUTZ</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-29-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. 577-11th St S.E.</u>				ADDRESS <u>577-11th St S.E.</u>		24a. REC'D BY REGISTRAR <u>SEP 28 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>H. H. Hedrick</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 28 1956

BUREAU V. 8

VS A15 (4)  
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

09608

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>P. G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>4691 BROOKS DR.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alta</u> Middle <u>MAE</u> Last <u>SHAYER</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1900</u> <u>9-15-95</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>14</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maplewood, N. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Deering</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Key E. Shaver</u>		Address <u>4691 Brooks Dr. Suitland Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Coronary Heart</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1</u> , 19 <u>56</u> , to <u>Sept 14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 14</u> , 19 <u>56</u> , and that death occurred at <u>2:45</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Brannin</u> M.D.		ADDRESS (Street, city or town, state) <u>6124 Central Ave</u>	
DATE SIGNED <u>9/14/56</u>			
PHYSICIAN'S NAME (Type) <u>N.M. BRAININ</u> Capital Gate Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>9-17-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladenburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Lee &amp; Sons</u>		ADDRESS <u>3004 SHINE Ave</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Qu. Lane</u>	
DATE <u>SEP 19 56</u>			

MEDICAL CERTIFICATION



09609

## CERTIFICATE OF DEATH

Reg. Dist. No.

9640

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Villa Heights Md</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Villa Heights, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3906 58th ave</b>		d. STREET ADDRESS <b>3906 58th Avenue, .</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>K.</b> Last <b>Shligel</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>16</b> , Year <b>1956</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 24, 1899</b>
9. AGE (In years last birthday) yrs. <b>56</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building Supplies</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Kurt Shligel</b>		14. MOTHER'S MAIDEN NAME <b>Ida Knocke</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>128 03 6534</b>	
17. INFORMANT <b>Johanna M Shligel</b>		Address <b>Villa Heights, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Lung</b> DUE TO <b>Generalized Carcinomatosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Profound Anemia</b> (c) <b>Profound Anemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>no</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>no</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1954</b> , 19 <b>Sept 17</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>8-16</b> , 19 <b>56</b> , and that death occurred at <b>9:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dayton O Watkins</b>		ADDRESS (Street, city or town, state) <b>5304 Annapolis Rd</b>	
PHYSICIAN'S NAME (Type) <b>DAYTON O WATKINS</b>		Bladensburg Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>9/20/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Lincoln Cemetery</b>		22d. LOCATION (City, town or county) (State) <b>Colman Manor, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F Gasch sons Hyattsville Md</b>		ADDRESS <b>Hyattsville Md</b>	
24a. REC'D BY REGISTRAR <b>SEP 21 '56</b>		24b. REGISTRAR'S SIGNATURE <b>W. Lee</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1  
Page 4  
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

89610

9601

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				d. STREET ADDRESS <b>5407 54th Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>James</b> C Middle <b>Shoaf</b> Last				4. DATE OF DEATH Month <b>Sept</b> 17 Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-3-72</b>		9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James R Shoaf</b>				14. MOTHER'S MAIDEN NAME <b>Harriet Newcomer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT Address <b>Hospital records Cheverly, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b> <b>20 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August</b> , 19 <b>53</b> , to <b>Sept 17</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Sept 17</b> , 19 <b>56</b> , and that death occurred at <b>8:45 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Gordon W. Kelley</b>				ADDRESS (Street, city or town, state) <b>6124-41st Ave Hyatts Md</b>			
PHYSICIAN'S NAME (Type) <b>Gordon W. Kelley</b>				DATE SIGNED <b>9/18/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/20/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Old Frame Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		24a. RECEIVED BY REGISTRAR DATE <b>9/21/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>			



CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. T.

SEP 21 1956

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9641

CERTIFICATE OF DEATH

09611

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seabrook</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seabrook</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box # 83 RFD</b>		d. STREET ADDRESS <b>Box # 83 RFD</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>August</b> Middle <b>Sjoberg</b> Last <b>Sjoberg</b>		<b>4. DATE OF DEATH</b> Month <b>Sept</b> Day <b>10</b> Year <b>1956</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Aug. 28th, 1865</b>
<b>9. AGE</b> (In years last birthday) <b>91</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>9</b> Days <b>10</b> Hours <b>19</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Blacksmith--Retired</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Self-employed</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Sweden</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Unknown</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give year or dates of service) <b>None</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	
<b>17. INFORMANT</b> <b>Elizabeth A. Howerton, Box #83 Seabrook, Md.</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic Heart Disease</b> DUE TO (c) <b>generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 hours</b> <b>years</b> <b>year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Resolving bilateral pneumonia</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <b>19</b> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that I attended the deceased from <b>Sept 3, 1956</b> , to <b>Sept 10, 1956</b> , that I last saw the deceased alive on <b>Sept 9, 1956</b> , and that death occurred at <b>11:30</b> M, from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <b>H. James Kurtz</b> M.D.		<b>ADDRESS</b> (Street, city or town, state) <b>RFD Bowie Md</b> <b>DATE SIGNED</b> <b>9/10/56</b>	
<b>PHYSICIAN'S NAME</b> (Type) <b>H. James Kurtz</b>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>22b. DATE THEREOF</b> <b>9/13/1956</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Washington Nat'l Cem.</b>	<b>22d. LOCATION</b> (City, town, or county) (State) <b>Suitland, Pr. Geo. Co., Md.</b>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W.W. Chambers Company, Riverdale, Md.</b>		<b>24a. RECEIVED BY REGISTRAR</b> <b>SEP 19 56</b> <b>24b. REGISTRAR'S SIGNATURE</b> <b>W. J. Leach</b>	

RECEIVED  
SEP 19 1956  
BUREAU V. 1

SEP 19 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9602

## CERTIFICATE OF DEATH

89612

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>16.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md.</b>		c. LENGTH OF STAY IN 1b <b>2 mo. 17 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pr. Geo. General</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Louise</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>September</b> Day <b>23</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 6, 1956</b>
9. AGE (In years last birthday) yrs. <b>75 4/2</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Howard Johnston Smith Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Estelle Stein</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>--</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Hospital records</b>		Address <b>Cheverly, Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO <b>754.2</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Atherosclerosis (V. septal defect)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/6/1956</b> , to <b>9/23/1956</b> , that I last saw the deceased alive on <b>9/23/56</b> , 19 <b>56</b> , and that death occurred at <b>6 P.</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Albert Roth</b>		DATE SIGNED <b>5 510 Madison St. Bethesda, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Albert Roth</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/25/ 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland.</b>	
24a. REC'D BY REGISTRAR <b>SEP 26 '56</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	

2177372XVI

CERTIFICATE OF DEATH

RECEIVED  
SEP 26 1956  
BUREAU V. 3

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		MAY 14 1956	
AGE		SEX	
35		Male	
RACE		COLOR	
White		White	
BIRTH DATE		BIRTH PLACE	
JAN 1 1921		MEMPHIS, TENN.	
MARRIAGE		EDUCATION	
MARRIED		HIGH SCHOOL	
OCCUPATION		CAUSE OF DEATH	
Clerical		Suicide	
MANNER OF DEATH		PLACE OF DEATH	
Suicide		Home	
CERTIFICATE OF DEATH		SIGNATURE OF DECEASED	
JAMES EARL RAY		JAMES EARL RAY	
DATE OF DEATH		DATE OF DEATH	
MAY 14 1956		MAY 14 1956	
PLACE OF DEATH		PLACE OF DEATH	
Home		Home	
MANNER OF DEATH		MANNER OF DEATH	
Suicide		Suicide	
OCCUPATION		OCCUPATION	
Clerical		Clerical	
EDUCATION		EDUCATION	
HIGH SCHOOL		HIGH SCHOOL	
MARRIAGE		MARRIAGE	
MARRIED		MARRIED	
BIRTH DATE		BIRTH DATE	
JAN 1 1921		JAN 1 1921	
BIRTH PLACE		BIRTH PLACE	
MEMPHIS, TENN.		MEMPHIS, TENN.	
RACE		RACE	
White		White	
COLOR		COLOR	
White		White	
NAME OF DECEASED		NAME OF DECEASED	
JAMES EARL RAY		JAMES EARL RAY	
DATE OF DEATH		DATE OF DEATH	
MAY 14 1956		MAY 14 1956	
PLACE OF DEATH		PLACE OF DEATH	
Home		Home	
MANNER OF DEATH		MANNER OF DEATH	
Suicide		Suicide	
OCCUPATION		OCCUPATION	
Clerical		Clerical	
EDUCATION		EDUCATION	
HIGH SCHOOL		HIGH SCHOOL	
MARRIAGE		MARRIAGE	
MARRIED		MARRIED	
BIRTH DATE		BIRTH DATE	
JAN 1 1921		JAN 1 1921	
BIRTH PLACE		BIRTH PLACE	
MEMPHIS, TENN.		MEMPHIS, TENN.	
RACE		RACE	
White		White	
COLOR		COLOR	
White		White	



1  
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9642  
CERTIFICATE OF DEATH

89613

Reg. Dist. No.

740

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Prince Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Brandywine</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Brandywine</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Agnes</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>9</b> Day <b>8</b> Year <b>19 56</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 8, 1888</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Smith</b>		14. MOTHER'S MAIDEN NAME <b>Marian Dent</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Viola Henderson</b>		Address <b>1230 Bladensburg Rd. Wash., D. C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>4420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Old age</b>		INTERVAL BETWEEN ONSET AND DEATH <b>yes</b> <b>yes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>55</b> , to <b>Sept 9</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Sept 9</b> , 19 <b>56</b> , and that death occurred at <b>3:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Richard H. Dohsen</b> M.D.		SIGNATURE <b>Richard H. Dohsen</b>	
PHYSICIAN'S NAME (Type) <b>Richard H. Dohsen</b>		SIGNATURE <b>Richard H. Dohsen</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-13-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St John's Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Clinton, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home</b>		ADDRESS <b>Waldorf, Md.</b>	
24a. REC'D BY REGISTRAR <b>SEP 14 1956</b>		24b. REGISTRAR'S SIGNATURE <b>d. H. Hedrick</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9603 CERTIFICATE OF DEATH

09614

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley, Md.</i>		c. LENGTH OF STAY IN 1b <i>16 hrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince George Gen. Hosp.</i>		d. STREET ADDRESS <i>6708 Forest Hill Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>Walter</i> Middle <i>Newton</i> Last <i>Smith</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>14</i> Year <i>1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/16/68</i>
9. AGE (In years last birthday) <i>88</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad Clerk</i>	
11. BIRTHPLACE (State or foreign country) <i>Mississippi</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George W. Smith</i>		14. MOTHER'S MAIDEN NAME <i>Annis Guess</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Hospital Records Chesley, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Retroperitoneal Hemorrhage</i> 451x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Ruptured Abdominal Aortic Aneurysm</i> DUE TO <i>12 hrs.</i> (c) <i>Arteriosclerosis of Aorta</i> DUE TO <i>12 hrs.</i> <i>?</i> INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Nov. 12, 1953</i> to <i>Sept. 14, 1956</i> , that I last saw the deceased alive on <i>September 13, 1956</i> , and that death occurred at <i>10:57 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Hans Wodak</i>		ADDRESS (Street, city or town, state) <i>30-C RIDGE Rd Greenbelt, Md.</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>9-14-56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/14/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>George Washington</i>	22d. LOCATION (City, town, or county) (State) <i>Hyattsville, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Eusebs sons</i>		ADDRESS <i>Hyattsville, Md.</i>	
24a. REC'D BY REGISTRAR <i>SEP 17 '56</i>		24b. REGISTRAR'S SIGNATURE <i>W. E. Leach</i>	

BUREAU V. S.

SEP 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

89615

## CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Hill, Md.</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jeremiah</u> Middle <u>Joseph</u> Last <u>Spillane</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/23/82</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GENERAL MAINTENANCE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INSTITUTION</u>	
11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN SPILLANE</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH CRONIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>158-28-0466</u>	
17. INFORMANT <u>Mrs. Hugh A Turnbull</u>		Address <u>6903 R. I. Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Surgery for Carcinoma of</u> DUE TO (c) <u>Sigmoid Colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/14/56</u> , 19 <u>56</u> , to <u>9/13/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/13/56</u> , 19 <u>56</u> , and that death occurred at <u>5:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. E. Musser</u>		DATE SIGNED <u>9/13/56</u>	
PHYSICIAN'S NAME (Type) <u>F. E. Musser</u>		ADDRESS (Street, city or town, state) <u>2409 Vernon St Londoner Hills, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/14/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>NEWARK, N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u>		24a. REC'D BY REGISTRAR <u>SEP 17 1956</u>	
ADDRESS <u>C-Riverdale</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
DECEASED		MALE		35		JAN 15 1921		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH	
JAN 17 1956		10:30 AM		NEW YORK		NEW YORK		NEW YORK		NEW YORK		JAN 17 1956		10:30 AM	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		RACE		COLOR		SEX	
HEART DISEASE		NATURAL		DRIVER		HIGH SCHOOL		CATHOLIC		WHITE		WHITE		MALE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH	
JAN 17 1956		10:30 AM		NEW YORK		NEW YORK		NEW YORK		NEW YORK		JAN 17 1956		10:30 AM	

RECEIVED  
SEP 17 1956  
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9564

## CERTIFICATE OF DEATH

09616

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Unknown</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>15 Mons.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hyattsville Conv. Home.</b>		d. STREET ADDRESS <b>5720 Walnut Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>ELEANOR</b> Last <b>STARR</b>		4. DATE OF DEATH Month <b>September</b> Day <b>16</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. <del>MARRIED</del> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <del>WIDOWED</del> <input type="checkbox"/> <del>DIVORCED</del> <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1874</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bell Telep. Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Watson town, Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob P. Starr</b>		14. MOTHER'S MAIDEN NAME <b>Agnes J. Sloan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>William P. Starr</b>		Address <b>6208 43d St. Hyatts., Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>332x</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Emphysema</b> (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-18-55</b> , 19 <b>55</b> , to <b>9-16-56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9-15-56</b> , 19 <b>56</b> , and that death occurred at <b>3:24</b> A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>John P. Clum</b> M.D.		<b>9-16-56</b>	
PHYSICIAN'S NAME (Type) <b>JOHN P. CLUM, M.D.</b>		<b>6110 43d Ave., Hyattsville, Md. 9/16/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sep. 18, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Watson town, Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Watson town, Pennsylvania.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO.</b>		ADDRESS <b>Riverdale, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>John P. Clum</b>	

**BUREAU V. S.**

SEP 18 1956

# RECEIVED

## MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forest Heights</b>		c. LENGTH OF STAY IN TB <b>2 Mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forest Heights</b>		d. STREET ADDRESS <b>304 Cree Dr.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>304 Cree Dr.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Linda</b>		First <b>B. E.</b>		Middle <b>Statter</b>		Last <b>Sept. 26 19 56</b>	
4. DATE OF DEATH Month <b>Sept.</b>		Day <b>26</b>		Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 28, 1956</b>	
9. AGE (In years last birthday) <b>2 Mo.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Karl O. Statter</b>		14. MOTHER'S MAIDEN NAME <b>Pauline Louise Armentrout</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Father Same as #2.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>asphyxia</b> <b>924.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>asphyxia</b> DUE TO (c) <b>asphyxia</b>		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>asphyxiated in bed clothing</b>					
20c. TIME OF INJURY Hour <b>2:35</b> p. m. Month, Day, Year <b>Sept 26 1956</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James I. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd M.D.</b>		DATE SIGNED <b>Sept 26, 1956</b>					
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 27, 1956</b>		22c. NAME OF CEMETERY OR <del>PREPARATORY</del> <b>Washington National</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville, Maryland.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Oct 1 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Carrie Campbell</b>	

RECEIVED

OCT 1 1956

BUREAU V. 3



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,7 FilmG205 10-11-56 et

## CERTIFICATE OF DEATH

09618

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Chesley, md</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>				d. STREET ADDRESS <u>Telegraph Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>E</u> Last <u>Stewart</u>				4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>w</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/11/1892</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Harry Stewart</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hospital</u> Address <u>Chesley, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>8 weeks</u> <u>7-10 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>1949</u> , 19 _____, to <u>9/29/</u> , 1956, that I last saw the deceased alive on <u>9/19/</u> , 1956, and that death occurred at <u>8 a.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Albert Roth</u> M.D. <u>5570 Madison St</u>				DATE SIGNED <u>9/27/56</u>			
PHYSICIAN'S NAME (Type) <u>ALBERT ROTH</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/1/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. S. Sacks sons</u> ADDRESS <u>Hyattsville Md</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 2 '56</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur</u>	

BUREAU V. S.

OCT 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12844

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MD</u> b. COUNTY <u>P. G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Barnfield</u> Middle <u>Stoughtenberg</u> Last <u>?</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>29</u> Year <u>56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic pulmonary emphysema</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 29</u> , 19 <u>56</u> , to <u>Sept 29</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Sept. 29</u> , 19 <u>56</u> , and that death occurred at <u>7:45</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Brainin</u> M.D.		ADDRESS (Street, city or town, state) <u>6124 Central Ave</u> DATE SIGNED <u>10/1/56</u>	
PHYSICIAN'S NAME (Type) <u>William BRAININ</u>		<u>Capitol Hill Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interment</u>	22b. DATE THEREOF <u>10.15.56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>C. of Md. Med. School</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
ADDRESS		DATE <u>DEC 17 '56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Reed</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE; 18

09619

9606

## CERTIFICATE OF DEATH

Reg. Dist. No.

242

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>414-48th Ave</u>				d. STREET ADDRESS <u>414-48th Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCIS WOODROW SULLIVAN</u>				4. DATE OF DEATH Month Day Year <u>Sept 10 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1913</u>	9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Surgeon</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Museum</u>		11. BIRTH PLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward Alexander Sullivan</u>				14. MOTHER'S MAIDEN NAME <u>Nettie Owens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT Address <u>Mrs F Sullivan 414-48th Ave, Capitol Heights Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanoma carcinoma</u> 190X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 11</u> , 19 <u>56</u> , to <u>Sept 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 10</u> , 19 <u>56</u> , and that death occurred at <u>11:25</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Brainin</u> M.D.				ADDRESS (Street, city or town, state) <u>6124 Central Ave</u>		DATE SIGNED <u>9/10/56</u>	
PHYSICIAN'S NAME (Type) <u>WM. BRAININ</u>				Capitol Heights Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/14/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u> ADDRESS <u>517 11th St.</u>				24a. REC'D BY REGISTRAR <u>SEP 13 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	





## MARYLAND STATE DEPARTMENT OF HEALTH

09620

2411 N. Charles Street, Baltimore

## 9565 CERTIFICATE OF DEATH

Reg. Dist. No. *145*

1. PLACE OF DEATH COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MD</i> COUNTY <i>Prince George</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Hyattsville</i> 15 <i>10 years</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Hyattsville</i> 15	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>5508 Emerson St.</i>		STREET ADDRESS (If rural, give location) <i>5508 Emerson St.</i>	
3. NAME OF DECEASED (Type or Print) <i>DRUGILLA</i>	(First) <i>B.</i> (Middle) <i>Thomas</i> (Last)	4. DATE OF DEATH (Month) <i>Sept.</i> (Day) <i>27</i> (Year) <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>7-23-1873</i>
9. AGE last birthday <i>83</i> yrs.		10. AGE last birthday If under 1 year: Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Howard Co., Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Elmer Hobbs</i>		14. MOTHER'S MAIDEN NAME <i>Georgia Hobbs</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY No. <i>none</i>	
17. INFORMANT <i>Shirley Thomas</i>		18. MEDICAL CERTIFICATION <i>5508 Emerson St.</i>	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 Immediate cause

(a) *Acute Coronary Occlusion*Antecedent cause(s)  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last(b) *Generalized Arteriosclerotic Heart Disease*

(c)

INTERVAL BETWEEN ONSET AND DEATH

*1 day**? years*II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICID HOMICIDE	(Specify) PLACE (Home, farm, factory, street, OF injury bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *November 1, 1956*, to *Sept 27, 1956*, that I last saw the deceasedalive on *Sept 27, 1956*, and that death occurred at *12:20 P.m.*, from the causes and on the date stated above.SIGNATURE *David J. Clayman, M.D.* (Degree or title) ADDRESS *6311 Balto Ave. Riverdale Md* DATE SIGNED *9/27/56*

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>Burial</i>	<i>10-1-56</i>	<i>Springfield</i>	<i>Hyattsville, Md.</i>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<i>9-28-56</i>	<i>James Lavery</i>	<i>Arthur H. Wright</i>	<i>Hyattsville, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 1 1956

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9607

## CERTIFICATE OF DEATH

09621

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights			
c. LENGTH OF STAY IN 1b 11 Days				d. STREET ADDRESS 320 48th Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John W. Middle Thompson Last Thompson				4. DATE OF DEATH Month Sept. 21 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar 31 1879	
9. AGE (In years last birthday) 77		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Capitol Power Plant Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Franklin Thompson		14. MOTHER'S MAIDEN NAME Delian Tippet	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Agnes Ontrich 320 48th Ave Cap Hts, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Cerebrovascular Disorders (b) Arteriosclerotic cardiovascular disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 9-10, 1956, to 9-31, 1956, that I last saw the deceased alive on 9-21, 1956, and that death occurred at 7:00A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John T. Lynn				ADDRESS (Street, city or town, state) 5241 St Barnabas Rd		DATE SIGNED 9/21	
PHYSICIAN'S NAME (Type) John T. Lynn				5241 St. Barnabas Road S.E.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-24-56		22c. NAME OF CEMETERY OR CREMATORY Philadelphia		22d. LOCATION (City, town, or county) (State) Forestville Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A Mattingly				ADDRESS 131-11		24a. REC'D BY REGISTRAR DATE 9-24-56	
24b. REGISTRAR'S SIGNATURE							





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09622

9608

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>5505 43rd. Place</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Raymond</u> Last <u>Thoms</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 4, 1956</u>	9. AGE (In years last birthday) <u>12</u> yrs.	IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Houston Thoms</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Mary Balcar</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Father: Same address</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Laceration of left sigmoid sinus</u> DUE TO (c) <u>Separation of occipito-parietal suture</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>9020</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell to floor from sofa in living room of his home.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12</u> p. m. <u>9-19- 19 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Hyattsville, Pr. Geo. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>Sept. 19, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/21/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 24 '56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Aw. Lewis</u>			

2077231XV6

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 24 1956

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9609 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **245**

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>			c. LENGTH OF STAY IN 1b <b>15 Minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>				d. STREET ADDRESS <b>8915 65th Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>La Rue</b> Middle <b>Priscilla</b> Last <b>Tame</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>24</b> Year <b>19 56</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 22, 1914</b>		
9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR Months <b>42</b> Days <b>42</b> Hours <b>42</b> Min.		IF UNDER 24 HRS. Hours <b>42</b> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Time keeper</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Airoplane</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Wilmer Kachelues</b>				14. MOTHER'S MAIDEN NAME <b>Sussannah Smith</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Joseph T. Pratt; 4409 Bennion Road, Silver Springs, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage; hemorrhage and shock</b>              DUE TO <b>811X</b>              Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.              DUE TO (b) <b>Massive lacerations of liver and spleen</b>              DUE TO (c) <b>Automobile accident</b></p> </div> <div style="width: 50%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Collision between automobile and street car.</b>						
20c. TIME OF INJURY Month, Day, Year Hour <b>5.00</b> p. m. <b>9-24-56</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Riverdale, pr. Georges, Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/28/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Gasch's Sons Hyattsville, Md.</b>				24. REC'D BY REGISTRAR <b>James Leary</b> DATE <b>Oct 1 1956</b>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED

OCT 1 1956

BUREAU V. 2

Collection between automobile and street car.

Street

10-1-56

Relative locations of liver and spleen

2. Peritoneal (peritoneal); peritoneal and spleen

2. Spleen, No.

Joseph T. Kelly, 1000 Remond Road, Albany

North Western

Continental

Alto

Continental

Alto

Continental

Alto

Alto

Alto

Alto

Alto

Alto

Alto

Alto

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09624

9644

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DISTRICT Hqts.</u>		c. LENGTH OF STAY IN 1b <u>1 year</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DISTRICT Hqts.</u>		d. STREET ADDRESS <u>7600 ATWOOD STREET</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7600 ATWOOD STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ELIZABETH TURNER</u>		4. DATE OF DEATH Month Day Year <u>SEPTEMBER 18 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 JUNE 1876</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MANNIE SMITH</u>		14. MOTHER'S MAIDEN NAME <u>KATE BAILEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ARCHIE TURNER-2344-G St., S.E. D.C. 20</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>6 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 17</u> , 19 <u>56</u> , to <u>Sept 18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 17</u> , 19 <u>56</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Fegan</u>		ADDRESS (Street, city or town, state) <u>2210 Nichols Ave S.E.</u>	
PHYSICIAN'S NAME (Type) <u>JOHN B. FEGAN</u>		DATE SIGNED <u>9-18-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/21/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc.</u>		24a. REC'D BY REGISTRAR <u>SEP 21 1956</u>	
ADDRESS <u>317 1/2 Ave. S.E. D.C. 3</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	



[illegible]

**BUREAU V. S.**

SEP 21 1959

RECEIVED

9610

## CERTIFICATE OF DEATH

09625

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>Washington, D.C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>			
c. LENGTH OF STAY IN TB <b>6 days</b>				d. STREET ADDRESS <b>234 F St. N.W.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Karl</b> Middle <b>Wendling</b> Last <b>Wendling</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>8</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-16-1893</b>	
9. AGE (In years last birthday) <b>63 yrs.</b>		IF UNDER 1 YEAR Months <b>63</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Austria</b>		11. BIRTHPLACE (State or foreign country) <b>Austria</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Mike Wendling</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Floor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>				16. SOCIAL SECURITY NO. <b>2806 Laurel Ave. Cheverly, Md.</b>			
17. INFORMANT <b>Regina C. Bass</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Man. Intra-peritoneal Rupture</b> <b>150X</b> DUE TO <b>Spiderman Cu Zophag. 8wls</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Spiderman Cu Zophag. 8wls</b> DUE TO (c) <b>Spiderman Cu Zophag. 8wls</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Aug 15, 1956</b> , to <b>Sept 8, 1956</b> , that I last saw the deceased alive on <b>Sept 7, 1956</b> , and that death occurred at <b>6:00 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Benjamin S. Miller</b>				ADDRESS (Street, city or town, state) <b>3824-34 St. Not Rainer</b>			
PHYSICIAN'S NAME (Type) <b>BENJAMIN S. MILLER MD</b>				DATE SIGNED <b>SEP 8 '56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				22b. DATE THEREOF <b>9/11/56</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Prince George County, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co</b>				ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>			
24a. REC'D BY REGISTRAR <b>SEP 13 '56</b>				24b. REGISTRAR'S SIGNATURE <b>W. H. Hines</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09626

9611

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard County</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>7 minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis Junction</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Fancis</b> Middle <b>Samuel</b> Last <b>White</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>28,</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 12, 1885</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Samuel Owen White</b>				14. MOTHER'S MAIDEN NAME <b>Juliet D'Andelet</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hilton White, 716 Forston Drive, Takoma Park,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular renal Disease.</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>Md.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Oct. 1, 1956 Meadowridge Mem. Park Maryland</b>				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>DeWitt Donaldson, General, Md.</b>				24a. REC'D BY REGISTRAR <b>0613 '56</b>		24b. REGISTRAR'S SIGNATURE <b>DeWitt Donaldson</b>	

MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John T. Williams	
Sex		Male	
Race		White	
Date of Birth		March 12, 1902	
Place of Birth		Maryland	
Usual Residence		Baltimore, Maryland	
Cause of Death		Cardiovascular renal disease	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	

**RECEIVED**  
OCT 3 1956  
**BUREAU V. S.**

John T. Williams, Jr.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9645

## CERTIFICATE OF DEATH

09627

Reg. Dist. No.

242

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Seat Pleasant</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>6000 Addison Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary Virginia</u> Middle <u>Wilburn</u> Last		4. DATE OF DEATH Month <u>Sept</u> Day <u>11</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 5 1893</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Kaldenbach</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ann Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Wash 27</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 420.0 DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Jan 15</u> , 19 <u>46</u> , to <u>Sept 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 10</u> , 19 <u>56</u> , and that death occurred at <u>10:10 P.M.</u> from the causes and on the date stated above.	
22. I certify that I attended the deceased from <u>Jan 15</u> , 19 <u>46</u> , to <u>Sept 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 10</u> , 19 <u>56</u> , and that death occurred at <u>10:10 P.M.</u> from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) <u>7005 Ritchie Rd SE</u> DATE SIGNED <u>9-11-56</u>	
ACTUAL SIGNATURE <u>W. Suit Ritchie</u> M.D.		22b. NAME OF CEMETERY OR CREMATORY <u>Addison Chapel Seat Pleasant Md.</u>	
PHYSICIAN'S NAME (Type) <u>W. Suit Ritchie M.D.</u>		22d. LOCATION (City, town, or county) (State) <u>Wash 27 D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/14/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Addison Chapel Seat Pleasant Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Wash 27 D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee's Sons - Wash. D.C.</u>		24. REC'D BY REGISTRAR <u>Sept 14-56</u>	
25. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED George Washington		DATE OF DEATH 1956	
AGE 60		SEX Male	
RACE White		RELIGION Roman Catholic	
MARRIAGE Married		EDUCATION High School	
OCCUPATION None		RESIDENCE 1000 North Washington St.	
CAUSE OF DEATH Congestive Heart Failure		IMMEDIATE CAUSE Myocardial Infarction	
DISEASE OR INJURY Coronary Arteriosclerosis		PERMANENT CAUSE Atherosclerosis	
DATE OF ONSET 2-11-56		DATE OF DEATH 2-11-56	
PLACE OF DEATH Home		ATTENDING PHYSICIAN Dr. J. H. Smith	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF DECEASED George Washington	

BUREAU V. 1

SEP 17 1956

RECEIVED

9612

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hospital</u>		d. STREET ADDRESS <u>4212 Longfellow St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Hillary</u> Middle <u>T.</u> Last <u>Willis</u>		4. DATE OF DEATH Month <u>September</u> Day <u>12</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-11-73</u>
9. AGE (In years last birthday) <u>83 1/2</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor of Medicine</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James S. Willis</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital chart</u>		Address <u>stated above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General arteriosclerosis</u> DUE TO (c) <u>10 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1945</u> to <u>Sept 12 1956</u> , that I last saw the deceased alive on <u>Sept 12</u> , 19 <u>56</u> , and that death occurred at <u>6:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Riverdale, Md</u> DATE SIGNED <u>9-12-56</u>			
ACTUAL SIGNATURE <u>L W Malin</u> M.D.			
PHYSICIAN'S NAME (Type) <u>L W MALIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9/14/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lat Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colman Manor Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. G. S. Sons</u>		ADDRESS <u>Hyattsville, Md</u>	
24a. REC'D BY REGISTRAR <u>SEP 17 1956</u>		24b. REGISTRAR'S SIGNATURE <u>James Seeger</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 17 1956

RECEIVED

9613

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley 4 md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Hospital</u>		d. STREET ADDRESS <u>5314 RHOAD ISLAND AVE</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First <u>Wilson</u> Middle Last		4. DATE OF DEATH <u>9/8</u> Month <u>9</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/7/56</u>
9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>DONALD HAMPTON WILSON</u>		14. MOTHER'S MAIDEN NAME <u>MARIE THERESA WILSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Cerebral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/7/56</u> , 19 <u>56</u> , to <u>9/8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/8/56</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Perkins</u>		DATE SIGNED <u>9/9/56</u>	
PHYSICIAN'S NAME (Type) <u>John W. Perkins</u>		ADDRESS (Street, city or town, state) <u>5301 Hamilton St. Hyattsville Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chesley Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Perkins</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 22 '56</u>	
ADDRESS <u>2077 184th Ave</u>		24b. REGISTRAR'S SIGNATURE <u>W. Perkins</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF SHERIFF	
19. SIGNATURE OF DEPUTY SHERIFF		20. SIGNATURE OF CONSTABLE		21. SIGNATURE OF JURY	
22. SIGNATURE OF GRAND JURY		23. SIGNATURE OF DISTRICT COURT		24. SIGNATURE OF COUNTY COURT	
25. SIGNATURE OF STATE COURT		26. SIGNATURE OF FEDERAL COURT		27. SIGNATURE OF SUPREME COURT	
28. SIGNATURE OF U.S. DISTRICT COURT		29. SIGNATURE OF U.S. COURT OF APPEALS		30. SIGNATURE OF U.S. SUPREME COURT	
31. SIGNATURE OF U.S. DEPARTMENT OF JUSTICE		32. SIGNATURE OF U.S. DEPARTMENT OF HEALTH		33. SIGNATURE OF U.S. DEPARTMENT OF AGRICULTURE	
34. SIGNATURE OF U.S. DEPARTMENT OF COMMERCE		35. SIGNATURE OF U.S. DEPARTMENT OF EDUCATION		36. SIGNATURE OF U.S. DEPARTMENT OF INTERIOR	
37. SIGNATURE OF U.S. DEPARTMENT OF LABOR		38. SIGNATURE OF U.S. DEPARTMENT OF NAVY		39. SIGNATURE OF U.S. DEPARTMENT OF WAR	
40. SIGNATURE OF U.S. DEPARTMENT OF ARMY		41. SIGNATURE OF U.S. DEPARTMENT OF AIR FORCE		42. SIGNATURE OF U.S. DEPARTMENT OF SPACE	
43. SIGNATURE OF U.S. DEPARTMENT OF DEFENSE		44. SIGNATURE OF U.S. DEPARTMENT OF ENERGY		45. SIGNATURE OF U.S. DEPARTMENT OF TRANSPORTATION	
46. SIGNATURE OF U.S. DEPARTMENT OF JUSTICE		47. SIGNATURE OF U.S. DEPARTMENT OF HEALTH		48. SIGNATURE OF U.S. DEPARTMENT OF AGRICULTURE	
49. SIGNATURE OF U.S. DEPARTMENT OF COMMERCE		50. SIGNATURE OF U.S. DEPARTMENT OF EDUCATION		51. SIGNATURE OF U.S. DEPARTMENT OF INTERIOR	
52. SIGNATURE OF U.S. DEPARTMENT OF LABOR		53. SIGNATURE OF U.S. DEPARTMENT OF NAVY		54. SIGNATURE OF U.S. DEPARTMENT OF WAR	
55. SIGNATURE OF U.S. DEPARTMENT OF ARMY		56. SIGNATURE OF U.S. DEPARTMENT OF AIR FORCE		57. SIGNATURE OF U.S. DEPARTMENT OF SPACE	
58. SIGNATURE OF U.S. DEPARTMENT OF DEFENSE		59. SIGNATURE OF U.S. DEPARTMENT OF ENERGY		60. SIGNATURE OF U.S. DEPARTMENT OF TRANSPORTATION	
61. SIGNATURE OF U.S. DEPARTMENT OF JUSTICE		62. SIGNATURE OF U.S. DEPARTMENT OF HEALTH		63. SIGNATURE OF U.S. DEPARTMENT OF AGRICULTURE	
64. SIGNATURE OF U.S. DEPARTMENT OF COMMERCE		65. SIGNATURE OF U.S. DEPARTMENT OF EDUCATION		66. SIGNATURE OF U.S. DEPARTMENT OF INTERIOR	
67. SIGNATURE OF U.S. DEPARTMENT OF LABOR		68. SIGNATURE OF U.S. DEPARTMENT OF NAVY		69. SIGNATURE OF U.S. DEPARTMENT OF WAR	
70. SIGNATURE OF U.S. DEPARTMENT OF ARMY		71. SIGNATURE OF U.S. DEPARTMENT OF AIR FORCE		72. SIGNATURE OF U.S. DEPARTMENT OF SPACE	
73. SIGNATURE OF U.S. DEPARTMENT OF DEFENSE		74. SIGNATURE OF U.S. DEPARTMENT OF ENERGY		75. SIGNATURE OF U.S. DEPARTMENT OF TRANSPORTATION	
76. SIGNATURE OF U.S. DEPARTMENT OF JUSTICE		77. SIGNATURE OF U.S. DEPARTMENT OF HEALTH		78. SIGNATURE OF U.S. DEPARTMENT OF AGRICULTURE	
79. SIGNATURE OF U.S. DEPARTMENT OF COMMERCE		80. SIGNATURE OF U.S. DEPARTMENT OF EDUCATION		81. SIGNATURE OF U.S. DEPARTMENT OF INTERIOR	
82. SIGNATURE OF U.S. DEPARTMENT OF LABOR		83. SIGNATURE OF U.S. DEPARTMENT OF NAVY		84. SIGNATURE OF U.S. DEPARTMENT OF WAR	
85. SIGNATURE OF U.S. DEPARTMENT OF ARMY		86. SIGNATURE OF U.S. DEPARTMENT OF AIR FORCE		87. SIGNATURE OF U.S. DEPARTMENT OF SPACE	
88. SIGNATURE OF U.S. DEPARTMENT OF DEFENSE		89. SIGNATURE OF U.S. DEPARTMENT OF ENERGY		90. SIGNATURE OF U.S. DEPARTMENT OF TRANSPORTATION	
91. SIGNATURE OF U.S. DEPARTMENT OF JUSTICE		92. SIGNATURE OF U.S. DEPARTMENT OF HEALTH		93. SIGNATURE OF U.S. DEPARTMENT OF AGRICULTURE	
94. SIGNATURE OF U.S. DEPARTMENT OF COMMERCE		95. SIGNATURE OF U.S. DEPARTMENT OF EDUCATION		96. SIGNATURE OF U.S. DEPARTMENT OF INTERIOR	
97. SIGNATURE OF U.S. DEPARTMENT OF LABOR		98. SIGNATURE OF U.S. DEPARTMENT OF NAVY		99. SIGNATURE OF U.S. DEPARTMENT OF WAR	
100. SIGNATURE OF U.S. DEPARTMENT OF ARMY		101. SIGNATURE OF U.S. DEPARTMENT OF AIR FORCE		102. SIGNATURE OF U.S. DEPARTMENT OF SPACE	

BUREAU V. 2

OCT 22 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09629

Reg. Dist. No.

9614

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kent Village</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>7319 Forest Road</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Kathleen</b> Middle <b>Winton</b> Last				<b>4. DATE OF DEATH</b> Month <b>September</b> Day <b>19,</b> Year <b>19 56</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Sept. 6, 1953</b>		<b>9. AGE</b> (In years last birthday) <b>3</b> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>Thomas J. Winton</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Marjorie T. Splaine</b>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Father, Same Address.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Compound, comminuted fracture of skull</b> (c) <b>825X</b> (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTREMAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile collision. Deceased was riding as a passenger.</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>4.50 p. m. 9- 19 1956</b>		<b>20d. INJURY OCCURRED</b> White <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Street</b>			
<b>20f. (City or town)</b> <b>Cheverly</b>		<b>20g. (County)</b> <b>Pr. Geo.</b>		<b>20h. (State)</b> <b>Md.</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Noturol causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <b>John T. Maloney, M.D.</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <b>September 19, 1956</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>9/24/56</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Airy</b>			
<b>22d. LOCATION (City, town, or county)</b> <b>Washington, D.C.</b>		<b>22e. (State)</b> <b>D.C.</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Hallup Funeral Home</b>		<b>ADDRESS</b> <b>Mt. Rainier</b>		<b>24a. RECORD REGISTRAR</b> <b>SEP 24 1956</b>			
<b>24b. REGISTRAR'S SIGNATURE</b> <b>W. T. Rainier</b>		<b>DATE</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]  
RESIDENCE: [illegible]  
OCCUPATION: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]

SEX: [illegible] AGE: [illegible]  
RACE: [illegible] COLOR: [illegible]  
RELIGION: [illegible]

CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF EXAMINER: [illegible]  
DATE: [illegible]

LOCALITY: [illegible]  
COUNTY: [illegible]  
STATE: [illegible]

DEATH CERTIFICATE NO. [illegible]  
FILE NO. [illegible]

REMARKS: [illegible]

DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]

SIGNATURE OF EXAMINER: [illegible]  
DATE: [illegible]

BUREAU V. S.

SEP 24 1956

RECEIVED

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09630

9615

## CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Height	
c. LENGTH OF STAY IN 1b 11 days		d. STREET ADDRESS 7312 Halleck Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alexander Middle Porter Last Windsor		4. DATE OF DEATH Month Sept. Day 3 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 Oct. 1886
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address Carrie Windsor, 7312 Halleck St. District Height Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Capital heart overage DUE TO (b) Hypertension DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/24, 1956, to 9/3, 1956, that I last saw the deceased alive on 9/3, 1956, and that death occurred at 2:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William Bravin M.D.		ADDRESS (Street, city or town, state) Capital Heights Md. DATE SIGNED 9/3/56	
PHYSICIAN'S NAME (Type) William Bravin			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/1956	
22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Suitland, Pr. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers C. 517-4 St. S. E.		24a. REC'D BY REGISTRAR DATE 5 SEP 5 1956	
		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

SEP 5 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 12 FilmG205 10-11-56 et  
9616  
CERTIFICATE OF DEATH

09631

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b 7 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5902 Euclid St		d. STREET ADDRESS 5902 Euclid St	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Zofia Middle K Last Wyczalkowska		4. DATE OF DEATH Month Sept 20, 1956. Day 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 11 1872
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jan Wyczalkowska		14. MOTHER'S MAIDEN NAME Scholastyka Bacciarelli	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT Address M. R. Wyczalkowska Cheverly, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162X DUE TO Pulmonary edema (b) Broukogenic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 8-12 hrs. 6mo. +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 1956 to Sep 20 1956, that I last saw the deceased alive on Sep 20 1956, and that death occurred at 9:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Chas. J. Albright, MD. 1025 Vermont Ave. N.W. Washington 5, DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/22/56	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery
22d. LOCATION (City, town, or county) (State) Washington D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE Sep 24 56	
24b. REGISTRAR'S SIGNATURE Alfred			

SEP 24 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09632

9617

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale, Md.</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hospital</u>		d. STREET ADDRESS <u>5007 Nicholson St</u>	
3. NAME OF DECEASED (Type or print) First <u>Maurice</u> Middle <u>John</u> Last <u>Zardus</u>		4. DATE OF DEATH Month <u>September</u> Day <u>11</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-21-1902</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR <u>54</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Draftsman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DRAFTSMAN</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Erminio Zardus</u>		14. MOTHER'S MAIDEN NAME <u>Lovenza Dolfabria</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Unknown Hospital chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate</u> DUE TO <u>with Metastases and</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>43</u> , to <u>Sept 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 11</u> , 19 <u>56</u> , and that death occurred at <u>4:15</u> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>L W Malin</u> M.D.		<u>Riverdale, Md 9-11-56</u>	
PHYSICIAN'S NAME (Type) <u>L. W. MALIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/12/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Darby, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u>		ADDRESS <u>Burial 2nd.</u>	
24a. REC'D BY REGISTRAR <u>Sept 14 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Sweeney</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED: *John J. [illegible]*  
AGE: *45*  
SEX: *Male*  
RACE: *White*  
DATE OF BIRTH: *3-21-1913*  
PLACE OF BIRTH: *New Jersey*  
OCCUPATION: *Police Officer*  
CAUSE OF DEATH: *Heart Disease*  
DATE OF DEATH: *9-17-1956*  
PLACE OF DEATH: *Home*  
SIGNATURE OF PHYSICIAN: *[illegible]*  
SIGNATURE OF REGISTRAR: *[illegible]*

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